ICD-10 Coordination and Maintenance Committee Meeting
September 12-13, 2017
Diagnosis Agenda

Welcome and announcements
Donna Pickett, MPH, RHIA
Co-Chair, ICD-10 Coordination and Maintenance Committee

Diagnosis Topics:

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ICD-10 TIMELINE

A timeline of important dates in the ICD-10 process is described below:

September 12-13, 2017	ICD-10 Coordination and Maintenance Committee Meeting. Those who wish to attend the ICD-10 Coordination and Maintenance Committee meeting **must have registered for the meeting online by September 1, 2017.** You must bring an official form of picture identification (such as a driver's license) in order to be admitted to the building. In compliance to The Real ID Act, enacted in 2005, (http://www.dhs.gov/real-id-enforcement-brief) the following states/territories: Maine, Minnesota, Missouri, Montana and Washington State **will not** gain access into any Federal Agencies using the **above states** driver's license or ID. This means CMS visitors from these states/territories will need to provide alternative proof of identification (**such as a passport**) to gain entrance into Baltimore-based and Bethesda CMS buildings, as well as the Humphrey Building in Washington.
September 2017	Webcast of the September 12-13, 2017 ICD-10 Coordination and Maintenance Committee meeting will be posted on the CMS webpage as follows: https://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/meetings.html
October 1, 2017	New and revised ICD-10-CM and ICD-10-PCS codes go into effect along with DRG changes. Final addendum available on web pages as follows: Diagnosis addendum - http://www.cdc.gov/nchs/icd/icd10cm.htm Procedure addendum – http://www.cms.gov/Medicare/Coding/ICD10/

October 2017	**There were not any new procedure codes discussed at the September 12-13, 2017 ICD-10 Coordination and Maintenance Committee meetings for implementation on April 1, 2018.**
November 13, 2017	**Deadline for receipt of public comments on proposed new codes and revisions discussed at the September 12-13, 2017 ICD-10 Coordination and Maintenance Committee meetings for implementation on October 1, 2018.**
January 8, 2018	**Deadline for requestors: Those members of the public requesting that topics be discussed at the March 6–7, 2018 ICD-10 Coordination and Maintenance Committee meeting must have their requests submitted to CMS for procedures and NCHS for diagnoses by this date.**
February 2018	Tentative agenda for the Procedure part of the March 6, 2018 ICD-10 Coordination and Maintenance Committee meeting posted on CMS webpage as follows: https://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/ICD-9-CM-C-and-M-Meeting-Materials.html Tentative agenda for the Diagnosis part of the March 7, 2018 ICD-10 Coordination and Maintenance Committee meeting posted on NCHS homepage as follows: http://www.cdc.gov/nchs/icd/icd10cm_maintenance.htm Federal Register notice of March 6–7, 2018 ICD-10 Coordination and Maintenance Committee Meeting will be published.
February 2, 2018	**On-line registration opens for the March 6–7, 2018 ICD-10 Coordination and Maintenance Committee meeting at: https://www.cms.gov/apps/events/default.asp**
March 2018	Because of increased security requirements, **those wishing to attend the March 6–7, 2018** ICD-10 Coordination and Maintenance Committee meeting must register for the meeting online at: **https://www.cms.gov/apps/events/default.asp** **Attendees must register online by February 2, 2018; failure to do so may result in lack of access to the meeting**.
March 6 – 7, 2018	ICD-10 Coordination and Maintenance Committee

	meeting.
March 2018	Webcast of the March 6-7, 2018 ICD-10 Coordination and Maintenance Committee meeting will be posted on the CMS webpage as follows: https://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/ICD-9-CM-C-and-M-Meeting-Materials.html
April 1, 2018	Any new ICD-10 codes to capture new diseases or technology on April 1, 2018, will be implemented.
April 6, 2018	**Deadline for receipt of public comments on proposed new codes and revisions discussed at the March 6–7, 2018 ICD-10 Coordination and Maintenance Committee meetings for implementation on October 1, 2018**.
April 2018	Notice of Proposed Rulemaking to be published in the Federal Register as mandated by Public Law 99-509. This notice will include references to the finalized FY 2019 ICD-10-CM diagnosis and ICD-10-PCS procedure codes to date. It will also include proposed revisions to the MS-DRG system based on ICD-10-CM/PCS codes on which the public may comment. The proposed rule can be accessed at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html?redirect=/AcuteInpatientPPS/IPPS/list.asp
June 2018	Final addendum posted on web pages as follows: Diagnosis addendum – http://www.cdc.gov/nchs/icd/icd10cm.htm Procedure addendum - http://cms.hhs.gov/Medicare/Coding/ICD10/index.html
July 13, 2018	**Deadline for requestors: Those members of the public requesting that topics be discussed at the September 11-12, 2018 ICD-10 Coordination and Maintenance Committee meeting must have their requests submitted to CMS for procedures and NCHS for diagnoses.**
August 1, 2018	Hospital Inpatient Prospective Payment System final rule to be published in the Federal Register as mandated by Public Law 99-509. This rule will also include links to all the final codes to be implemented on October 1, 2018. This rule can be accessed at:

	http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html?redirect=/AcuteInpatientPPS/IPPS/list.asp
August 2018	Tentative agenda for the Procedure part of the September 11-12, 2018 ICD-10 Coordination and Maintenance Committee meeting will be posted on the CMS webpage at – https://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/ICD-9-CM-C-and-M-Meeting-Materials.html Tentative agenda for the Diagnosis part of the September 11-12, 2018 ICD-10 Coordination and Maintenance Committee meeting will be posted on the NCHS webpage at - http://www.cdc.gov/nchs/icd/icd10cm_maintenance.htm Federal Register notice for the September 11-12, 2018 ICD-10 Coordination and Maintenance Committee meeting will be published. This will include the tentative agenda.
August 3, 2018	**On-line registration opens for the September 11-12, 2018 ICD-10 Coordination and Maintenance Committee meeting at: https://www.cms.gov/apps/events/default.asp**
September 3, 2018	Because of increased security requirements, those wishing to attend the September 11-12, 2018 ICD-10 Coordination and Maintenance Committee meeting must register for the meeting online at: **https://www.cms.gov/apps/events/default.asp** **Attendees must register online by September 3, 2018; failure to do so may result in lack of access to the meeting.**
September 11-12, 2018	ICD-10 Coordination and Maintenance Committee meeting. Those who wish to attend the ICD-10 Coordination and Maintenance Committee meeting **must have registered for the meeting online by September 3, 2018.** You must bring an official form of picture identification (such as a driver's license) in order to be admitted to the building.
September 2018	Webcast of the September 11-12, 2018 ICD-10 Coordination and Maintenance Committee meeting will be posted on the CMS webpage as follows: https://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/meetings.html

	Summary report of the Diagnosis part of the September 11-12, 2018 ICD-10 Coordination and Maintenance Committee meeting report will be posted on NCHS homepage as follows: http://www.cdc.gov/nchs/icd/icd10cm_maintenance.htm
October 1, 2018	New and revised ICD-10-CM and ICD-10-PCS codes go into effect along with DRG changes. Final addendum available on web pages as follows: Diagnosis addendum - http://www.cdc.gov/nchs/icd/icd10cm.htm Procedure addendum – http://www.cms.gov/Medicare/Coding/ICD10/
October 16, 2018	**Deadline for receipt of public comments on proposed new codes discussed at the September 11-12, 2018 ICD-10 Coordination and Maintenance Committee meetings for implementation on April 1, 2019.**
November 2018	Any new ICD-10 codes required to capture new technology that will be implemented on the following April 1 will be announced. Information on any new codes to be implemented April 1, 2019 will be posted on the following websites: http://www.cdc.gov/nchs/icd/icd10cm.htm http://www.cms.gov/Medicare/Coding/ICD10/
November 12, 2018	**Deadline for receipt of public comments on proposed new codes and revisions discussed at the September 11-12, 2018 ICD-10 Coordination and Maintenance Committee meetings for implementation on October 1, 2019.**

Webcast and Dial-In Information

- The meeting will begin promptly at 9am ET and will be webcast.
- Toll-free dial-in access is available for participants who cannot join the webcast:
  Phone: Tuesday, September 12, 2017: 1-844-396-8222; Meeting ID: 907 558 361
  Wednesday, September 13, 2017: 1-844-396-8222; Meeting ID: 902 209 427
- **If participating via the webcast or dialing in you do NOT need to register on-line f or the meeting.**

This meeting is being webcast via CMS at http://www.cms.gov/live/. By your attendance, you are giving consent to the use and distribution of your name, likeness and voice during the meeting. You are also giving consent to the use and distribution of any personally identifiable information that you or others may disclose about you during the meeting. Please do not disclose personal health information.

NOTE: In compliance to The Real ID Act, enacted in 2005, the following states/territories: American Samoa, Louisiana, Minnesota, New Hampshire, and New York **will not** gain access into any Federal Agencies using the **above states** driver's license or ID. This means CMS visitors from these states/territories will need to provide alternative proof of identification (**such as a passport**) to gain entrance into Baltimore-based CMS building.

Contact Information
Mailing address:

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ICD-9-CM Coordination and Maintenance Committee
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Hyattsville, Maryland 20782
Fax: (301) 458-4022

Comments on the diagnosis proposals presented at the ICD Coordination and Maintenance Committee meeting should be sent to the following email address: nchsicd10CM@cdc.gov

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NCHS Classifications of Diseases web page:
http://www.cdc.gov/nchs/icd.htm
Please consult this web page for updated information

Abscess of Anal and Rectal Regions

Most experts categorize abscesses of the anal and rectal regions according to their anatomic location: perianal, ischiorectal, intersphincteric, and supralevator. Perianal abscesses are the most common, comprising over half of all anorectal abscesses. They are superficially located adjacent to the anus. Ischiorectal abscesses are the next most common location, located deep to the superficial subcutaneous fascia in the perirectal region. Superficial to the levator and anal sphincter muscles in the ischiorectal space. Intersphincteric abscesses occur between the external and internal sphincter muscles. Supralevator abscesses are located deep to the levator muscle in the true pelvis. The anatomic details determine appropriate treatment and accurate prognostication.

The proposal to create new codes for specific anatomical locations was presented at the September 2015 and March 2016 C&M meeting at the request of The Patient Assessment and Outcome Committee of the American Association for the Surgery of Trauma. Modifications have been made to the topic based on public comments and is now presented for reconsideration.

The following tabular modifications are being requested:

TABULAR MODIFICATIONS

K61 Abscess of anal and rectal regions

Includes: Abscess of anal and rectal regions
Cellulitis of anal and rectal regions

K61.0 Anal abscess
Perianal abscess

Revise Excludes~~1~~2: Intrasphincteric abscess (K61.4)
Add Intersphincteric abscess (K61.4)

New sub-subcategory K61.3 Ischiorectal abscess
Delete ~~Abscess of ischiorectal fossa~~

New code K61.31 Horseshoe abscess

New code K61.32 Ischiorectal abscess
Add Abscess of ischiorectal fossa
Add Ischiorectal abscess, NOS

K61.4 Intrasphincteric abscess
Add Intersphincteric abscess

New code K61.5 Supralevator abscess

Abnormal findings on diagnostic imaging of testis

Patients sometime have an abnormality of the testicle detected on an imaging study performed for genitourinary or non-genitourinary reasons, and further testing and/or procedures would be indicated. Such testing may include further imaging or lab tests, and surgery may include biopsy or radical surgery. The differential diagnosis includes a variety of both malignant and non-malignant conditions.

The available codes in ICD-10-CM are for abnormal urologic imaging or testicular cancer. Currently, there is no unique code for reporting abnormal findings on diagnostic imaging of testis.

American Urological Association (AUA) is requesting the following new codes to identify these conditions.

TABULAR MODIFICATIONS

R93 Abnormal findings on diagnostic imaging of other body structures

R93.8 Abnormal findings on diagnostic imaging of other specified body structures

Delete		~~Abnormal finding by radioisotope localization of placenta~~
Delete		~~Abnormal radiological finding in skin and subcutaneous tissue~~
Delete		~~Mediastinal shift~~
New sub-subcategory	R93.81	Abnormal radiologic findings on diagnostic imaging of testis, testes
New code	R93.811	Abnormal radiologic findings on diagnostic imaging of right testis
New code	R93.812	Abnormal radiologic findings on diagnostic imaging of left testis
New code	R93.813	Abnormal radiologic findings on diagnostic imaging of testes, bilateral
New code	R93.819	Abnormal radiologic findings on diagnostic imaging of unspecified testis
New code	R93.89	Abnormal findings on diagnostic imaging of other specified body structures
Add		Abnormal finding by radioisotope localization of placenta
Add		Abnormal radiological finding in skin and subcutaneous tissue
Add		Mediastinal shift

Abnormal Levels in Urine Collection

The American Urological Association (AUA) is proposing the creation of new codes for specific abnormal findings in urine collection. This proposal has been revised based on public comments received following the March 2016 Coordination and Maintenance meeting.

One of the most commonly used diagnostic tests for patients who form kidney stones is a urine collection test looking for abnormal levels of certain substances. When these abnormalities are identified, treatment can be directed to reduce the risk of future stone formation. For example, patients with high levels of urine calcium (hypercalciuria) may be treated with thiazide diuretics, those with high levels of oxalate (hyperoxaluria) may be treated with dietary changes or medications, those with low citrate levels (hypocitraturia) may be treated with citrate medications, and those with high levels of uric acid (hyperuricosuria) may be treated with dietary measures and possibly treatment of an underlying condition.

The existing code E72.53, hyperoxaluria, is for a childhood inborn error of metabolism primary hyperoxaluria, which is a diagnostic condition that can be determined by genetic testing. This is different than someone who has an idiopathic or diet-induced mild elevation of oxalate in the urine who does not have the genetic inborn error of metabolism.

To help better capture the unique characteristics of these abnormal findings and to help with research and public health, AUA is requesting the following ICD-10-CM tabular modifications. The changes are shown in bold.

TABULAR MODIFICATIONS

E72 Other disorders of amino-acid metabolism

E72.5 Disorders of glycine metabolism

Revise **E72.53 <u>Primary</u> Hyperoxaluria**
Oxalosis
Oxaluria

R82 Other and unspecified abnormal findings in urine

R82.9 Other and unspecified abnormal findings in urine
R82.99 Other abnormal findings in urine

Delete ~~Cells and casts in urine~~
Delete ~~Crystalluria~~
Delete ~~Melanuria~~
New Code R82.991 Hypocitraturia
New Code R82.992 Hyperoxaluria
Add **Excludes1: Primary Hyperoxaluria (E72.53)**

New Code	R82.993	Hyperuricoscuria
New Code	R82.994	Hypercalciuria
New Code	R82.998	Other abnormal findings in urine Cells and casts in urine Crystalluria Melanuria

Anemia due to Myelosuppressive Antineoplastic Chemotherapy

Anemia is relatively common in various types of cancer, due to a number of different mechanisms. Antineoplastic chemotherapy is widely used for various cancers, and can have a number of side effects, one of which can be anemia. Certain types of antineoplastic chemotherapy can have a myelosuppressive effect. In some cases, anemia may be treated with erythropoiesis stimulating agents (ESAs). However, some recent studies have showed negative health effects from ESAs, so there have been changes in recommendations on how these should be used.

It is possible for antineoplastic chemotherapy to cause various different types of anemia. If it causes an aplastic anemia, or a sideroblastic anemia, there are specific codes for these, which should be used instead of the anemia due to antineoplastic chemotherapy code(s), and should therefore be excluded from it.

It can be appropriate to use ESAs in anemia that is due to myelosuppression, related to antineoplastic chemotherapy. It has been requested that a specific code be created for anemia due to myelosuppressive antineoplastic chemotherapy, and that this be differentiated from anemia due to antineoplastic chemotherapy via mechanisms other than myelosuppression. This request is from the Centers for Medicare and Medicaid Services.

In order to better differentiate the mechanism of action causing the myelosuppression, it is also requested to create specific codes, within new sub-subcategories. The sub-subcategory T45.11, Poisoning by, adverse effect of and underdosing of cytotoxic, myelosuppressive, antineoplastic drugs, would include alkylating drugs, anthracyclines and other cytotoxic antibiotics, antimetabolites, anti-microtubule agents, heavy metals including platinum drugs, topoisomerase agents, vinca alkaloids and etoposide. The sub-subcategory T45.12, Poisoning by, adverse effect of and underdosing of myelosuppressive antineoplastic drugs acting via mechanisms other than marrow cytotoxicity, would include anti-angiogenesis drugs, epidermal growth factor inhibitors, and protein kinase inhibitors. The table of drugs and chemicals would be updated to reflect these new subcategories and codes.

There has not been a way to identify with ICD-10-CM codes any adverse effects or issues specifically related to erythropoiesis-stimulating agents. Thus, it is proposed to create a new sub-Subcategory, T45.81, Poisoning by, adverse effect of and underdosing of erythropoiesis-stimulating agents. This would have specific codes for the types of poisonings, and for adverse effects, as well as underdosing.

Reference

Rodgers GM 3rd, Becker PS, Blinder M, et. al. Cancer- and chemotherapy-induced anemia. J Natl Compr Canc Netw. 2012 May;10(5):628-53.
http://www.jnccn.org/content/10/5/628.long
doi: 10.6004/jnccn.2012.0064

TABULAR MODIFICATIONS

D64 Other anemias

D64.8 Other specified anemias

D64.81 Anemia due to antineoplastic chemotherapy

Add — Excludes1: sideroblastic anemia due to drugs (D64.2)

New code — D64.810 Anemia due to myelosuppressive antineoplastic chemotherapy

New code — D64.818 Anemia due to antineoplastic chemotherapy via other mechanisms

Add — Anemia due to antineoplastic chemotherapy via mechanisms other than myelosuppression

New code — D64.819 Anemia due to antineoplastic chemotherapy, unspecified

T45 Poisoning by, adverse effect of and underdosing of primarily systemic and hematological agents, not elsewhere classified

The appropriate 7th character is to be added to each code from category T45

- A initial encounter
- D subsequent encounter
- S sequela

T45.1 Poisoning by, adverse effect of and underdosing of antineoplastic and immunosuppressive drugs

Delete — ~~T45.1X Poisoning by, adverse effect of and underdosing of antineoplastic and immunosuppressive drugs~~

Delete — ~~T45.1X1 Poisoning by antineoplastic and immunosuppressive drugs, accidental (unintentional)~~
~~Poisoning by antineoplastic and immunosuppressive drugs NOS~~

Delete	~~T45.1X2~~	~~Poisoning by antineoplastic and immunosuppressive drugs, intentional self-harm~~
Delete	~~T45.1X3~~	~~Poisoning by antineoplastic and immunosuppressive drugs, assault~~
Delete	~~T45.1X4~~	~~Poisoning by antineoplastic and immunosuppressive drugs, undetermined~~
Delete	~~T45.1X5~~	~~Adverse effect of antineoplastic and immunosuppressive drugs~~
Delete	~~T45.1X6~~	~~Underdosing of antineoplastic and immunosuppressive drugs~~
New sub-subcategory	T45.11	Poisoning by, adverse effect of and underdosing of cytotoxic, myelosuppressive, antineoplastic drugs
New code	T45.111	Poisoning by cytotoxic, myelosuppressive, antineoplastic drug, accidental (unintentional)
Add		Poisoning by cytotoxic, myelosuppressive, antineoplastic drug NOS
New code	T45.112	Poisoning by cytotoxic, myelosuppressive, antineoplastic drug, intentional self-harm
New code	T45.113	Poisoning by cytotoxic, myelosuppressive, antineoplastic drug, assault
New code	T45.114	Poisoning by cytotoxic, myelosuppressive, antineoplastic drug, undetermined
New code	T45.115	Adverse effect of cytotoxic, myelosuppressive, antineoplastic drug
New code	T45.116	Underdosing of cytotoxic, myelosuppressive, antineoplastic drug
New sub-subcategory	T45.12	Poisoning by, adverse effect of and underdosing of myelosuppressive antineoplastic drugs acting via mechanisms other than marrow cytotoxicity
New code	T45.121	Poisoning by myelosuppressive antineoplastic drug acting via mechanisms other than marrow cytotoxicity, accidental (unintentional)
Add		Poisoning by myelosuppressive antineoplastic drug acting via mechanisms other than marrow cytotoxicity NOS
New code	T45.122	Poisoning by myelosuppressive antineoplastic drug acting via mechanisms other than marrow cytotoxicity, intentional self-harm

New code	T45.123	Poisoning by myelosuppressive antineoplastic drug acting via mechanisms other than marrow cytotoxicity, assault
New code	T45.124	Poisoning by myelosuppressive antineoplastic drug acting via mechanisms other than marrow cytotoxicity, undetermined
New code	T45.125	Adverse effect of myelosuppressive antineoplastic drug acting via mechanisms other than marrow cytotoxicity
New code	T45.126	Underdosing of myelosuppressive antineoplastic drug acting via mechanisms other than marrow cytotoxicity
New sub-subcategory	T45.19	Poisoning by, adverse effect of and underdosing of other antineoplastic and immunosuppressive drugs
New code	T45.191	Poisoning by other antineoplastic and immunosuppressive drugs, accidental (unintentional)
Add		Poisoning by other antineoplastic and immunosuppressive drugs NOS
New code	T45.192	Poisoning by other antineoplastic and immunosuppressive drugs, intentional self-harm
New code	T45.193	Poisoning by other antineoplastic and immunosuppressive drugs, assault
New code	T45.194	Poisoning by other antineoplastic and immunosuppressive drugs, undetermined
New code	T45.195	Adverse effect of other antineoplastic and immunosuppressive drugs
New code	T45.196	Underdosing of other antineoplastic and immunosuppressive drugs
	T45.8	Poisoning by, adverse effect of and underdosing of other primarily systemic and hematological agents
Delete	~~T45.8X~~	~~Poisoning by, adverse effect of and underdosing of other primarily systemic and hematological agents~~
Delete	~~T45.8X1~~	~~Poisoning by other primarily systemic and hematological agents, accidental (unintentional)~~ ~~Poisoning by other primarily systemic and hematological agents NOS~~

Delete	~~T45.8X2~~	~~Poisoning by other primarily systemic and hematological agents, intentional self-harm~~
Delete	~~T45.8X3~~	~~Poisoning by other primarily systemic and hematological agents, assault~~
Delete	~~T45.8X4~~	~~Poisoning by other primarily systemic and hematological agents, undetermined~~
Delete	~~T45.8X5~~	~~Adverse effect of other primarily systemic and hematological agents~~
Delete	~~T45.8X6~~	~~Underdosing of other primarily systemic and hematological agents~~

New sub-subcategory	T45.81	Poisoning by, adverse effect of and underdosing of erythropoiesis-stimulating agents
Add		Poisoning by, adverse effect of and underdosing of erythropoietin
New code	T45.811	Poisoning by erythropoiesis-stimulating agents, accidental (unintentional)
New code		Poisoning by erythropoiesis-stimulating agents NOS
New code	T45.812	Poisoning by erythropoiesis-stimulating agents, intentional self-harm
New code	T45.813	Poisoning by erythropoiesis-stimulating agents, assault
New code	T45.814	Poisoning by erythropoiesis-stimulating agents, undetermined
New code	T45.815	Adverse effect of erythropoiesis-stimulating agents
New code	T45.816	Underdosing of erythropoiesis-stimulating agents

New sub-subcategory	T45.89	Poisoning by, adverse effect of and underdosing of other primarily systemic and hematological agents
New code	T45.891	Poisoning by other primarily systemic and hematological agents, accidental (unintentional)
Add		Poisoning by other primarily systemic and hematological agents NOS
New code	T45.892	Poisoning by other primarily systemic and hematological agents, intentional self-harm
New code	T45.893	Poisoning by other primarily systemic and hematological agents, assault

New code	T45.894	Poisoning by other primarily systemic and hematological agents, undetermined
New code	T45.895	Adverse effect of other primarily systemic and hematological agents
New code	T45.896	Underdosing of other primarily systemic and hematological agents

TABLE OF DRUGS AND CHEMICALS MODIFICATIONS

There are 183 entries in the table of drugs and chemicals that reference code T45.1-, and also 96 entries that reference code T45.8-. This shows examples of revisions and new entries to be added to support certain of the new codes, but is not an exhaustive list of these changes.

The following drugs groups and classes (with examples) are to be entered or revised in the Table of Drugs and Chemicals, referencing T45.11-, Poisoning by, adverse effect of and underdosing of cytotoxic, myelosuppressive, antineoplastic drugs:

Alkylating drugs
Anthracyclines and other cytotoxic antibiotics
Antimetabolites
Anti-microtubule agents
Heavy metals—including platinum drugs (e.g., cisplatin)
Topoisomerase inhibitor antineoplastic agents (e.g., etoposide)
Vinca alkaloids (anti-mitotic and anti-microtubule; e.g., vincristine)

Examples of revisions to the Table of Drugs and Chemicals for T45.11-.

Substance	Poisoning Accidental (unintentional)	Poisoning Intentional self-harm	Poisoning Assault	Poisoning Undetermined	Adverse effect	Underdosing
Alkylating drug NEC	~~T45.1X1~~ T45.111	~~T45.1X2~~ T45.112	~~T45.1X3~~ T45.113	~~T45.1X4~~ T45.114	~~T45.1X5~~ T45.115	~~T45.1X6~~ T45.116
Antibiotic - anticancer	~~T45.1X1~~ T45.111	~~T45.1X2~~ T45.112	~~T45.1X3~~ T45.113	~~T45.1X4~~ T45.114	~~T45.1X5~~ T45.115	~~T45.1X6~~ T45.116
Antimetabolite	~~T45.1X1~~ T45.111	~~T45.1X2~~ T45.112	~~T45.1X3~~ T45.113	~~T45.1X4~~ T45.114	~~T45.1X5~~ T45.115	~~T45.1X6~~ T45.116
Cancer chemotherapy drug regimen	~~T45.1X1~~ T45.111	~~T45.1X2~~ T45.112	~~T45.1X3~~ T45.113	~~T45.1X4~~ T45.114	~~T45.1X5~~ T45.115	~~T45.1X6~~ T45.116
Cisplatin	~~T45.1X1~~ T45.111	~~T45.1X2~~ T45.112	~~T45.1X3~~ T45.113	~~T45.1X4~~ T45.114	~~T45.1X5~~ T45.115	~~T45.1X6~~ T45.116
Etoposide	~~T45.1X1~~ T45.111	~~T45.1X2~~ T45.112	~~T45.1X3~~ T45.113	~~T45.1X4~~ T45.114	~~T45.1X5~~ T45.115	~~T45.1X6~~ T45.116
Vincristine	~~T45.1X1~~ T45.111	~~T45.1X2~~ T45.112	~~T45.1X3~~ T45.113	~~T45.1X4~~ T45.114	~~T45.1X5~~ T45.115	~~T45.1X6~~ T45.116

Examples of new entries to be added to the Table of Drugs and Chemicals for T45.11-.

Substance	Poisoning Accidental (unintentional)	Poisoning Intentional self-harm	Poisoning Assault	Poisoning Undetermined	Adverse effect	Underdosing
Anthracycline	T45.111	T45.112	T45.113	T45.114	T45.115	T45.116
Antibiotic - cytotoxic	T45.111	T45.112	T45.113	T45.114	T45.115	T45.116
	T45.111	T45.112	T45.113	T45.114	T45.115	T45.116
Anti-microtubule cancer chemotherapy agent	T45.111	T45.112	T45.113	T45.114	T45.115	T45.116
Heavy metal based antineoplastic agent	T45.111	T45.112	T45.113	T45.114	T45.115	T45.116
Platinum based antineoplastic agent	T45.111	T45.112	T45.113	T45.114	T45.115	T45.116
Topoisomerase inhibitor antineoplastic agents	T45.111	T45.112	T45.113	T45.114	T45.115	T45.116
Vinca alkaloid antineoplastic agents	T45.111	T45.112	T45.113	T45.114	T45.115	T45.116

The following are to be entered or revised in the Table of Drugs and Chemicals, referencing T45.12, Poisoning by, adverse effect of and underdosing of myelosuppressive antineoplastic drugs acting via mechanisms other than marrow cytotoxicity.

Anti-Angiogenesis drugs (e.g., bevacizumab, sorafenib, sunitinib, pazopanib, everolimus)
Epidermal Growth Factor inhibitors (includes monoclonal antibodies that target the epidermal growth factor receptor, e.g., cetuximab; also tyrosine kinase inhibitors, a type of protein kinase inhibitor, e.g., gefitinib and erlotinib)
Protein Kinase inhibitors

Examples for new entries to be added to the Table of Drugs and Chemicals for T45.12-.

Substance	Poisoning Accidental (unintentional)	Poisoning Intentional self-harm	Poisoning Assault	Poisoning Undetermined	Adverse effect	Underdosing
Angiogenesis inhibitor	T45.121	T45.122	T45.123	T45.124	T45.125	T45.126
Anti-angiogenesis drug	T45.121	T45.122	T45.123	T45.124	T45.125	T45.126
Epidermal growth factor inhibitor	T45.121	T45.122	T45.123	T45.124	T45.125	T45.126
Protein kinase inhibitor	T45.121	T45.122	T45.123	T45.124	T45.125	T45.126
Tyrosine kinase inhibitor	T45.121	T45.122	T45.123	T45.124	T45.125	T45.126

Angelman Syndrome

Angelman Syndrome (AS) is a genetic neurodevelopmental disorder characterized by cognitive disability, motor dysfunction, speech impairment, hyperactivity, seizures, excessive laughing, decreased sleeping, and gastroesophageal reflux. AS generally results from deletion, mutation or silencing of the gene for ubiquitin-protein ligase E3A (UBE3A). This gene is imprinted in neurons with maternal expression and paternal silencing, meaning only the gene from the mother is active. The gene is located within the 15q11-q13 chromosomal region. This ubiquitin-protein ligase ordinarily works to catalyze a step in the breakdown of certain proteins, and it is thought that high levels of such proteins are the cause of the neurological problems that are found in AS.

There are broadly four causes of AS. About 70% of AS is due to de novo maternal deletion of 15q11.2-q13. About 2% is due to paternal uniparental disomy of 15q11.2-q13, meaning there are two copies, but both are from the father. About 2-3% is due to imprinting defects, meaning that even though there is a maternal copy of the gene, it is "turned off," as if that copy came from the father. Finally, about 25% of AS is due to mutations in UBE3A (single gene, rather than affecting multiple genes). Problems are generally more severe in those who have a deletion, while those with paternal uniparental disomy or imprinting defects have less severe problems.

Deletions usually start and end at common breakpoints. Certain symptoms are associated with deletions involving particular regions, such as epilepsy. Some cases with large deletions are also associated with hypopigmentation or oculocutaneous albinism. There have been different classes of deletions identified.

A chromosomal deletion of the same region of chromosome 15, of paternal origin, causes a different disorder, Prader-Willi syndrome.

Angelman syndrome affects an estimated 1 in 12,000 to 20,000 people. With the life expectancy being close to normal, this would correspond to about 15,000 to 25,000 people in the U.S. being affected.

In the WHO ICD-10, and in ICD-10-CM, Angelman syndrome is coded to Q93.5, Other deletions of part of a chromosome. It is proposed to expand this, to create a specific code for Angelman syndrome.

The Angelman Biomarkers and Outcome Measures Alliance has requested that a specific ICD-10-CM code be created for Angelman syndrome in all its variations. A specific code or codes would be helpful for tracking and research purposes.

References

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TABULAR MODIFICATIONS

Option #1

Q93 Monosomies and deletions from the autosomes, not elsewhere classified

Q93.5 Other deletions of part of a chromosome

Delete ~~Angelman syndrome~~

New code Q93.51 Angelman syndrome

New code Q93.59 Other deletions of part of a chromosome

Option #2

	Q93	Monosomies and deletions from the autosomes, not elsewhere classified	
	Q93.5	Other deletions of part of a chromosome	
Delete		~~Angelman syndrome~~	
New sub-Subcategory		Q93.51	Angelman syndrome
New code		Q93.511	Angelman syndrome due to chromosomal deletion
New code		Q93.512	Angelman syndrome due to paternal uniparental disomy
Add			Angelman syndrome due to paternal UPD
New code		Q93.513	Angelman syndrome due to imprinting defect
New code		Q93.514	Angelman syndrome due to UBE3A mutation
New code		Q93.518	Angelman syndrome due to other cause
Add			Angelman syndrome, testing does not identify genetic abnormality
New code		Q93.519	Angelman syndrome, unspecified
New code		Q93.59	Other deletions of part of a chromosome

Brow ptosis

Brow ptosis, or a drooping brow, is one of the most common diagnoses in oculoplastic surgery. Brow ptosis is usually the result of the involutional changes that affect the forehead muscles and soft tissue, but may also occur as a result of facial nerve palsy, trauma, and surgery. Minor differences between the two eyes and periocular areas can be obvious and a brow ptosis of only 3 – 4 mm can affect facial expression significantly. A drooping brow can lead to mechanical drooping of eyelid skin causing significant mechanical ptosis and impairment of vision. A permanent way to treat brow ptosis is by means of an operation called a brow lift.

This is a representation of a proposal presented at the March 2017 Coordination and Maintenance meeting. The change is to add new codes to report laterality.

The American Academy of Ophthalmology proposes the following tabular modifications. The changes are shown in bold.

TABULAR MODIFICATIONS

	H57	Other disorders of eye and adnexa	
New subcategory	H57.8	Other specified disorders of eye and adnexa	
New sub-subcategory	H57.81	Brow ptosis	
New code		**H57.811**	**Brow ptosis, right eye**
New code		**H57.812**	**Brow ptosis, left eye**
New code		**H57.813**	**Brow ptosis, bilateral**
New code		**H57.819**	**Brow ptosis, unspecified eye**
New code	H57.89	Other specified disorders of eye and adnexa	

Cannabis Withdrawal

The American Psychiatric Association (APA) is requesting new ICD-10-CM codes for Cannabis Withdrawal. Although ICD-10-CM codes exist for withdrawal from substances known to cause a clinically significant withdrawal syndrome [i.e., alcohol (F10.23), opioids (F11.23 and F11.93), sedatives, hypnotics, or anxiolytics (F13.23 and F13.93), cocaine (F14.23), other stimulants (F15.23 and F15.93), and nicotine (F17.203, F17.213, F17.223, F17.293)], no such code exists for withdrawal from cannabis. At the time the Mental, Behavioral and Neurodevelopmental Disorders chapter of ICD-10-CM was being developed in the late 1990's, cannabis withdrawal was not a recognized clinically significant syndrome.

Research on cannabis withdrawal conducted over the last 10 years supported the distinct nature and the clinical importance of cannabis withdrawal, resulting in the inclusion of Cannabis Withdrawal as a disorder in DSM-5 (Budney et al., 2004; 2006). Cannabis Withdrawal is relatively common among those with Cannabis Dependence, and persons with Cannabis Dependence comprise a substantial proportion of treatment admissions for substance use disorders. A distinct code will increase public awareness of this disorder, and perhaps lead to increased treatment seeking for those experiencing Cannabis Dependence.

Cannabis withdrawal is characterized by symptoms such as irritability, anger, or aggression; nervousness or anxiety; sleep difficulty; decreased appetite or weight loss; restlessness; depressed mood; and physical symptoms such as abdominal pain, shakiness/tremors, sweating, fever, chills, or headache, that develop within a week of cessation of cannabis use that has been heavy and prolonged. Cannabis withdrawal is clearly distinct from other withdrawal disorders. Although some initially believed that what was being called cannabis withdrawal might reflect withdrawal symptoms caused by cessation of concurrently abused substances, evidence accumulated over the past 15 years has clearly shown that cannabis withdrawal is a distinct syndrome (Budney et al., 2004; 2006).

Since the ICD-10-CM substance use disorder codes depend on whether or not withdrawal is occurring in the context of Cannabis Dependence, two new codes are being requested: one code (F12.23) for cases of withdrawal occurring in someone with Cannabis Dependence, and a second code (F12.93) for cases of physiological withdrawal from cannabis occurring in a person who is regularly taking cannabis in contexts other than Cannabis Dependence (for example, under medical supervision).

The American Psychiatric Association is requesting the following tabular modifications:

TABULAR MODIFICATIONS

F12 Cannabis related disorders
F12.2 Cannabis dependence
F12.20 Cannabis dependence, uncomplicated
F12.21 Cannabis dependence in remission
F12.22 Cannabis dependence with intoxication
New code F12.23 Cannabis dependence with withdrawal
F12.25 Cannabis dependence with psychotic disorder
F12.28 Cannabis dependence with other cannabis-induced disorder
F12.280 Cannabis dependence with cannabis-induced anxiety disorder
F12.288 Cannabis dependence with other cannabis-induced disorder
Cannabis use disorder, moderate, with cannabis-induced sleep disorder
Cannabis use disorder, severe with cannabis-induced sleep disorder
Delete ~~Cannabis withdrawal~~
F12.9 Cannabis use, unspecified
F12.90 Cannabis use, unspecified, uncomplicated
F12.92 Cannabis use, unspecified with intoxication
New code F12.93 Cannabis use, unspecified with withdrawal
F12.95 Cannabis use, unspecified, with psychotic disorder
F12.98 Cannabis use, unspecified, with other cannabis-induced disorder
F12.980 Cannabis use, unspecified with cannabis-induced anxiety disorder
F12.988 Cannabis use, unspecified, with other cannabis-induced disorder

References:
Budney AJ, Hughes JR, Moore, BA, Vandry R: Review of the Validity and Significance of Cannabis Withdrawal Syndrome, Am J Psychiatry 2004: 161:1967-1977

Budney AJ, Hughes JR. The cannabis withdrawal syndrome. Current Opinion in Psychiatry 2006: 19:233-238

Central Obesity

Central obesity, also called visceral adiposity, is characterized with increased adipose tissue around the intra-abdominal organs. It may also be referred to as abdominal obesity, visceral obesity, or truncal obesity. Central obesity has been found to be associated with metabolic syndrome, insulin resistance, diabetes, cardiovascular disease and several malignancies including prostate, breast and colorectal cancers. Related to cardiovascular disease, central obesity increases the susceptibility to arterial hypertension and ischaemic heart disease.

It has been proposed to create a specific code for central obesity.

References

Shuster A, Patlas M, Pinthus JH, Mourtzakis M. The clinical importance of visceral adiposity: a critical review of methods for visceral adipose tissue analysis. Br J Radiol. 2012 Jan; 85(1009): 1–10. https://dx.doi.org/10.1259/bjr/38447238 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3473928/

Griffith ML, Younk LM, Davis SN. Visceral Adiposity, Insulin Resistance, and Type 2 Diabetes. Am J Lifestyle Med. 2010; 4(3): 230-243. https://dx.doi.org/10.1177/1559827609360959

TABULAR MODIFICATIONS

	E65	Localized adiposity Fat pad
New subcategory	E65.8	Other localized adiposity
New code	E65.81	Central obesity
Add		Abdominal obesity
Add		Truncal obesity
Add		Visceral adiposity
Add		Visceral obesity
New code	E65.89	Other localized adiposity
New code	E65.9	Localized adiposity, unspecified

Coma scale, best motor response, abnormal flexion

The Glasgow Coma Score is widely used following traumatic brain injury, for predicting outcomes. ICD-10-CM codes related to the Glasgow Coma Score (GCS) are in use, and there have been a number of comments related to these codes. Based on input from multiple sources, it is proposed to make certain changes for clarity.

It is proposed to add inclusion terms, clarifying how each of these ICD-10-CM codes relate to a specific GCS component score.

For code R40.233, "Coma scale, best motor response, abnormal," it is proposed to change the title to "Coma scale, best motor response, abnormal flexion."

References

---. Glasgow Coma Scale. CDC.
https://www.cdc.gov/masstrauma/resources/gcs.pdf

Majdan M, Steyerberg EW, Nieboer D, Mauritz W, Rusnak M, Lingsma HF. Glasgow coma scale motor score and pupillary reaction to predict six-month mortality in patients with traumatic brain injury: comparison of field and admission assessment. J Neurotrauma. 2015 Jan 15;32(2):101-8.
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TABULAR MODIFICATIONS

R40 Somnolence, stupor and coma

R40.2 Coma

Note: One code from each subcategory, R40.21-R40.23, is required to complete the coma scale

R40.21 Coma scale, eyes open

R40.211 Coma scale, eyes open, never
Add Coma scale eye opening score of 1

R40.212 Coma scale, eyes open, to pain
Add Coma scale eye opening score of 2

R40.213 Coma scale, eyes open, to sound
Add Coma scale eye opening score of 3

R40.214 Coma scale, eyes open, spontaneous

Add — Coma scale eye opening score of 4

R40.22 Coma scale, best verbal response

R40.221 Coma scale, best verbal response, none
Add — Coma scale verbal score of 1

R40.222 Coma scale, best verbal response, incomprehensible words
Add — Coma scale verbal score of 2

R40.223 Coma scale, best verbal response, inappropriate words
Add — Coma scale verbal score of 3

R40.224 Coma scale, best verbal response, confused conversation
Add — Coma scale verbal score of 4

R40.225 Coma scale, best verbal response, oriented
Add — Coma scale verbal score of 5

R40.23 Coma scale, best motor response

The following appropriate 7th character is to be added to subcategory R40.23-:

0 unspecified time
1 in the field [EMT or ambulance]
2 at arrival to emergency department
3 at hospital admission
4 24 hours or more after hospital admission

R40.231 Coma scale, best motor response, none
Add — Coma scale motor score of 1

R40.232 Coma scale, best motor response, extension
Add — Coma scale motor score of 2

Revise — R40.233 Coma scale, best motor response, abnormal flexion
Revise — Abnormal flexure posturing to pain or noxious stimuli (~~0~~2-5 years of age)
Add — Coma scale motor score of 3

	R40.234	Coma scale, best motor response, flexion withdrawal
Add		Coma scale motor score of 4
	R40.235	Coma scale, best motor response, localizes pain
Add		Coma scale motor score of 5
	R40.236	Coma scale, best motor response, obeys commands
Add		Coma scale motor score of 6

Cyclical Vomiting Syndrome

Cyclical vomiting syndrome is described by episodes of severe vomiting that have no noticeable cause. Episodes can last for days or hours and alternate with symptom-free periods of time. Each episode tends to start at the same time of day, last the same length of time and occur with the same symptoms and level of intensity. Cyclical vomiting syndrome may or may not be related to migraines. Treatment usually involves medications, including anti-nausea and migraine therapies, that may help lessen symptoms

Currently, in ICD-10-CM, Cyclical vomiting is indexed to code G43.AO, Cyclical vomiting, not intractable. These codes fall within the code category of G43-, Migraine. In ICD-9-CM, Cyclical vomiting (not related to migraines) was captured under code 536.2, Persistent vomiting. Code 536.2 crosswalks to ICD-10-CM code R11.10. Vomiting, unspecified. This code doesn't seem to adequately represent the clinical significance of the disorder in the treatment of cyclical vomiting syndrome not related to migraines.

The changes have been requested by the Coding Clinic Editorial Advisory Board. The American Academy of Pediatrics has reviewed and supports this proposal.

The following tabular modifications are being proposed:

TABULAR MODIFICATIONS

G43 Migraine
G43.A Cyclical vomiting
Add — Excludes1: Cyclical vomiting syndrome (R11.15)
G43.A0 Cyclical vomiting, not intractable
Cyclical vomiting, without refractory migraine
G43.A1 Cyclical vomiting, intractable
Cyclical vomiting, with refractory migraine

R11 Nausea and vomiting
R11.1 Vomiting
R11.10 Vomiting, unspecified
Vomiting NOS
R11.11 Vomiting without nausea
R11.12 Projectile vomiting
R11.13 Vomiting of fecal matter
R11.14 Bilious vomiting
Bilious emesis
New code — R11.15 Cyclical vomiting syndrome
Add — Excludes1: Cyclical vomiting (G43.A-)

Duchenne Muscular Dystrophy

Muscular dystrophies form a heterogeneous group of diseases caused by a host of genetic mutations whose common expression is to diminish the action or impede the production of proteins involved in muscle growth and development; the result is a progressive and irreversible debilitation and deterioration of muscle mass in specific body regions. Muscular dystrophies show marked differences in prevalence, severity of symptoms and complications, modes of inheritance, ages at onset, and the patterns of muscle and organs affected. Muscular dystrophies are incurable; current treatments are designed to mitigate symptoms, delay progression, and prevent complications.

There are several major types and dozens of sub-types of muscular dystrophy.[1] Most types and sub-types, however, are extremely rare. The four most common types of muscular dystrophy are: Becker, Duchenne, Facioscapulohumeral (FSH) and Myotonic. Myotonic muscular dystrophy currently has a specific ICD-10-CM code (G71.11). Becker and Duchenne muscular dystrophy both are caused by problems with the same protein, dystrophin.

New codes are being requested for Becker or Duchenne (together), and Facioscapulohumeral muscular dystrophies. Creating specific codes for the most common types of muscular dystrophies will facilitate the surveillance of these diseases; will allow more accurate estimates of their incidence, prevalence, survivorship, mortality and its causes, injuries, symptoms, and health visits; will help to identify factors that influence health status and secondary conditions. At a larger scale, ICD-10-CM codes can be used to compare health information across hospitals, regions, clinical settings, countries, and even across time in a given location and to facilitate the evaluation of clinical guidelines.

This proposal reflects the technical advice of the American Academy of Pediatrics and is submitted on behalf of the Parent Project Muscular Dystrophy (PPMD), the Foundation to Eradicate Duchenne (FED), and the FSH Society.

References

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2. Mah, JK, Korngut L, Dykeman J, Day L, Pringsheim T, Jette N. A systematic review and meta-analysis on the epidemiology of Duchenne and Becker muscular dystrophy. Neuromuscul Disord 2014; 24(6):482-91. https://doi.org/10.1016/j.nmd.2014.03.008
3. Mah JK, Korngut L, Fiest KM, Dykeman J, Day LJ, Pringsheim T, Jette N. A Systematic Review and Meta-analysis on the Epidemiology of the Muscular Dystrophies. Can J Neurol Sci 2016; 43(1):163-77. https://doi.org/10.1017/cjn.2015.311

TABULAR MODIFCATIONS

G71 Primary disorders of muscles

Excludes2: arthrogryposis multiplex congenita (Q74.3)
metabolic disorders (E70-E88)
myositis (M60.-)

G71.0 Muscular dystrophy

Delete ~~Autosomal recessive, childhood type, muscular dystrophy resembling Duchenne or Becker muscular dystrophy~~

Delete ~~Benign [Becker] muscular dystrophy~~

Delete ~~Benign scapuloperoneal muscular dystrophy with early contractures [Emery-Dreifuss]~~

Delete ~~Congenital muscular dystrophy NOS~~

Delete ~~Congenital muscular dystrophy with specific morphological abnormalities of the muscle fiber~~

Delete ~~Distal muscular dystrophy~~

Delete ~~Facioscapulohumeral muscular dystrophy~~

Delete ~~Limb-girdle muscular dystrophy~~

Delete ~~Ocular muscular dystrophy~~

Delete ~~Oculopharyngeal muscular dystrophy~~

Delete ~~Scapuloperoneal muscular dystrophy~~

Delete ~~Severe [Duchenne] muscular dystrophy~~

New code G71.01 Duchenne or Becker muscular dystrophy
Autosomal recessive, childhood type, muscular dystrophy resembling
Benign [Becker] muscular dystrophy
Severe [Duchenne] muscular dystrophy

New code G71.02 Facioscapulohumeral muscular dystrophy
Scapulohumeral muscular dystrophy

New code G71.08 Other specified muscular dystrophies

		Benign scapuloperoneal muscular dystrophy with early contractures [Emery-Dreifuss] Congenital muscular dystrophy NOS Congenital muscular dystrophy with specific morphological abnormalities of the muscle fiber Distal muscular dystrophy Limb-girdle muscular dystrophy Ocular muscular dystrophy Oculopharyngeal muscular dystrophy Scapuloperoneal muscular dystrophy
New code	G71.09	Muscular dystrophy, unspecified

Ecstasy Poisoning

The street drug ecstasy, 3,4-methylenedioxymethamphetamine (MDMA), has both hallucinogenic (psychedelic) and stimulant effects. It has been abused by millions of Americans, in a wide range of settings, and by diverse demographic subgroups. Although many users think it to be safe, it can cause a number of problems in cases of poisoning.

Ecstasy dependence and abuse are classified in ICD-10-CM with hallucinogens. However, the effects in cases of poisoning are more related to its stimulant effects, and its chemical structure being a substituted amphetamine.

Some of the potential adverse health effects of ecstasy include anxiety, irritability, aggression, panic attacks, sleep disturbance, reduced mental ability, nausea, muscle cramps, hyperthermia, dehydration, elevated blood pressure, arrhythmias, heart failure, and kidney failure. Symptoms of ecstasy poisoning or overdose can include elevated blood pressure, panic attacks, loss of consciousness, seizures, and potentially hyperthermia.

It is proposed to add new specific codes for ecstasy poisoning, with accidental intent, as well as intentional self-harm, assault, and undetermined intent. This proposal is based on NCHS internal review, related to questions received about classification of ecstasy abuse and dependence as a hallucinogen, but classification of ecstasy poisoning as an amphetamine derivative. Being able to identify poisoning by ecstasy, and differentiate it from other amphetamines, will allow better tracking of the effects of these different drugs.

TABULAR MODIFICATIONS

T43 Poisoning by, adverse effect of and underdosing of psychotropic drugs, not elsewhere classified

T43.6 Poisoning by, adverse effect of and underdosing of psychostimulants

New subcategory	T43.64	Poisoning by ecstasy
Add		Poisoning by MDMA
Add		Poisoning by 3,4-methylenedioxymethamphetamine
New code	T43.641	Poisoning by ecstasy, accidental (unintentional)
Add		Poisoning by ecstasy NOS
New code	T43.642	Poisoning by ecstasy, intentional self-harm
New code	T43.643	Poisoning by ecstasy, assault
New code	T43.644	Poisoning by ecstasy, undetermined

Elevated Lipoprotein(a)

Elevated Lipoprotein(a) [Lp(a)] is a highly prevalent, codominant genetic lipid disorder and risk factor for cardiovascular disease (CVD) including heart attack, stroke and peripheral arterial disease as well as calcific aortic valve stenosis (CAVS). Blood levels of Lp(a) span a wide range (<0.1 mg/dL to over 200 mg/dL), with median levels globally of 10-15 mg/dL. Elevated Lp(a) level (>30 mg/dL or >75 nmol/L) affects about 20 to 30% of the global population, and is casually linked to increased atherothrombotic events and CAVS. High Lp(a) is one of the most common hereditary disorders, although many who have it have not been recognized.

Lp(a) is a large particle, with two large linked components, one that is similar to low-density lipoprotein (LDL), termed apolipoprotein B (apoB), and another that is similar to plasminogen, termed apolipoprotein(a) (apo(a)). The apo(a) part varies widely in form, particularly between different individuals, giving rise to over 40 different forms of different sizes. Smaller and denser forms are associated with higher cardiac risk, in a fashion that is determined by genetics, and cannot be controlled by diet or exercise. Lp(a) may affect cardiac risk in more than one way. The apo(a) being structurally like plasminogen, but without its effects, may interfere with fibrinolysis, and thus promote thrombosis. Also, the apoB part of Lp(a) may promote atherosclerosis similarly to LDL cholesterol.

Elevated Lp(a) is usually silent, without signs or symptoms, and not able to be detected by history or physical. Elevated Lp(a) is measured by a blood test. Recent genome-wide association and Mendelian randomization studies indicate that Lp(a) is a causal and independent risk factor for CVD. Thus, the first sign of elevated Lp(a) can be sudden death from myocardial infarction or stroke. There has been development of selective and potent Lp(a)-lowering agents, which has re-stimulated interest in Lp(a). Levels of Lp(a) may also be lowered by apheresis. Further understanding of Lp(a) pathophysiology and its clinical importance in the treatment of CVD may help reduce the residual risk present following current standard therapy. Lp(a) testing is recommended for those at intermediate or high CVD risk, a strong family history, recurrent CVD, premature CVD, and those unresponsive to guideline recommended therapies. Measurement of Lp(a) levels in patients with at least intermediate CVD risk are supported by several recent guidelines from medical societies, including the National Lipid Association, the Canadian Cardiovascular Society Guidelines for the Management of Dyslipidemia for the Prevention of Cardiovascular Disease in the Adult, and from the Task Force for the Management of Dyslipidaemias of the European Society of Cardiology (ESC) and European Atherosclerosis Society (EAS), the 2016 ESC/EAS Guidelines for the Management of Dyslipidaemias.

An elevated level of Lp(a) is the only identifiable risk factor in many patients with CVD, particularly younger (<65 years old), reflecting its genetic contribution to CVD risk. In others, it compounds the risk from other risk factors. Finding a high level of Lp(a) in an asymptomatic patient would indicate the need for more aggressive treatment of other cardiovascular risk factors.

To enable tracking individuals and their families with high Lp(a), the Lipoprotein(a) Foundation and its scientific advisory board have proposed to create a specific ICD-10-CM code for elevated Lp(a). This will enable clinicians to more easily convey the etiology of CVD and CAVS risk, and

to tailor preventative and treatment strategies for this, as well as providing a basis for data collection, for research into the CVD impact of this lipid.

References

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TABULAR MODIFICATIONS

E78 Disorders of lipoprotein metabolism and other lipidemias

E78.4 Other hyperlipidemia

Delete ~~Familial combined hyperlipidemia~~

New code E78.41 Elevated Lipoprotein(a)

New code E78.49 Other hyperlipidemia
Familial combined hyperlipidemia

Z83 Family history of other specific disorders

Z83.4 Family history of other endocrine, nutritional and metabolic diseases

New sub-subcategory Z83.43 Family history of other disorder of lipoprotein metabolism and other lipidemias

New code Z83.430 Family history of elevated lipoprotein(a)

New code Z83.438 Family history of other disorder of lipoprotein metabolism and other lipidemia
Family history of familial combined hyperlipidemia

Encounter for screening for certain developmental disorders in childhood

At the March 2014 Coordination and Maintenance meeting, the American Academy of Pediatrics (AAP) requested new codes for Z13.4, Encounter for screening for certain developmental disorders in childhood. Based on public comments received and further review, the proposal was modified and represented at the March 2017 C&M Meeting. The American Academy of Pediatrics has subsequently submitted another proposal for further modifications for this category.

The AAP noted that encounters where developmental screening is the main (or only) reason for the encounter, it occurs outside of the routine infant or child exam. AAP's request for additional code modifications is in response to Medicaid's implementation of a developmental screening measure on the Medicaid Child Core Set that is required for patients receiving benefits through their State Medicaid program. It is very important for physicians who provide early and periodic screening, diagnostic and treatment (EPSDT) services for patients to have a clear-cut way to denote when a patient either presents for or receives a developmental screen versus an autism screen.

Both developmental and autism screens are part of the American Academy of Pediatrics "recommendations for pediatric preventive health care," so both services are provided for many pediatric patients at a variety of encounters, but typically the well-child or preventive medicine exam.

The Academy respectfully submits a revised code proposal for new codes under Z13.4 to specify whether the screen is for global developmental delays or for autism. The Academy is also requesting revision of the excludes note at Z13.4 to allow the use of both codes during routine well child exams. Since there is an overlap with the previously submitted proposals, this proposal is comprehensive of all requested changes.

TABULAR MODIFICATIONS

Z00 Encounter for general examination without complaint, suspected or reported diagnosis

Z00.1 Encounter for newborn, infant and child health examinations

Z00.12 Encounter for routine child health examination

Delete	~~Encounter for development testing of infant or child~~
	Health check (routine) for child over 28 days old
Add	Immunizations appropriate for age
Add	Routine vision and hearing testing

Add		Routine developmental screening of infant or child
	Z13	Encounter for screening for other diseases and disorders
New subcategory	Z13.4	Encounter for screening for certain developmental disorders in childhood Encounter for screening for developmental handicaps in early childhood
Add		Encounter for development testing of infant or child
Revise		Excludes~~1~~ 2: Encounter for routine child health examination (Z00.12-)
New code		Z13.40 Encounter for screening for unspecified developmental delays
New code		Z13.41 Encounter for autism screening
New code		Z13.42 Encounter for screening for global developmental delays (milestones)
Add		Encounter for screening for developmental handicaps in early childhood
New code		Z13.49 Encounter for screening for other developmental delays

Factitious Disorder

Factitious Disorder is characterized by the individual's falsification of medical or psychological signs and symptoms or induction of injury or disease that is associated with identified deception. The current codes in ICD-10-CM are based on whether the symptoms that are being fabricated are physical in nature, psychological in nature, or both. This distinction is not clinically meaningful in terms of differentiating types of patients or selecting treatment.

A much more clinically important distinction is whether the falsified or intentionally produced signs or symptoms are imposed by the patient on himself or herself (i.e., factitious disorder imposed on self, which is the most typical variety of factitious disorder), versus imposed on another person, typically a dependent child (factious disorder imposed on another).

The latter form of factitious disorder, which is also referred to as factitious disorder by proxy or Munchausen's syndrome by proxy, has not previously been given its own code despite the significant morbidity and mortality associated with this condition as well as its forensic implications. It is important to note that the diagnosis is given to the perpetrator of the falsified illness and not the victim, even though it is the victim that displays the signs and symptoms of the falsified illness. The victim is given the appropriate abuse diagnosis.

This proposal was presented at the September 2016 & March 2017 Coordination and Maintenance meeting by the American Psychiatric Association (APA). In response to the comments received, APA has revised (again) the proposed new coding structure for factitious disorder. What the comments have in common is the concern about changing the meaning of the existing codes (F68.10, F68.11, and F68.12). The following proposal maintains the meaning of the current codes but proposes to include Factitious disorder imposed on another (factitious disorder by proxy) by adding a separate code.

The following tabular modifications are being requested:

TABULAR MODIFICATIONS

F68 Other disorders of adult personality and behavior

Revise F68.1 Factitious disorder <u>imposed on self</u>
Compensation neurosis
Elaboration of physical symptoms for psychological reasons
Hospital hopper syndrome
Münchausen's syndrome
Peregrinating patient

		Excludes2:factitial dermatitis (L98.1) person feigning illness (with obvious motivation) (Z76.5)
Revise		F68.10 Factitious disorder, imposed on self, unspecified
Revise		F68.11 Factitious disorder imposed on self, with predominantly psychological signs and symptoms
Revise		F68.12 Factitious disorder imposed on self, with predominantly physical signs and symptoms
Revise		F68.13 Factitious disorder imposed on self, with combined psychological and physical signs and symptoms
New Code	F68.2	Factitious Disorder imposed on another
Add		Factitious Disorder by proxy
Add		Münchausen's by proxy

Gestational Diabetes Mellitus in Pregnancy, Poorly Controlled

The American Congress of Obstetricians and Gynecologists (ACOG) is requesting new codes to report poorly controlled gestational diabetes mellitus in pregnancy. .

Currently gestational diabetes mellitus in pregnancy that is documented as poorly controlled is reported with code O24.419, Gestational diabetes mellitus in pregnancy, unspecified control. This code is now assigned when the clinical documentation does not specify whether the diabetes is controlled, uncontrolled or when documented as poorly controlled.

ACOG proposes the following tabular modifications.

TABULAR MODIFICATION

	O24	Diabetes mellitus in pregnancy, childbirth, and the puerperium
	O24.4	Gestational diabetes mellitus
		O24.41 Gestational diabetes mellitus in pregnancy
New code		O24.416 Gestational diabetes mellitus in pregnancy, poorly controlled
		O24.42 Gestational diabetes mellitus in childbirth
New code		O24.426 Gestational diabetes mellitus in childbirth, poorly controlled
		O24.43 Gestational diabetes mellitus in the puerperium
New code		O24.436 Gestational diabetes mellitus in the puerperium, poorly controlled

Immunization Not Carried Out

Given the rise of quality metrics related to patient vaccine rates, it becomes increasingly important to relay information related to vaccine delay or non-compliance. Vaccine shortages either due to problem in manufacturing or the manufacturer's inability to deliver the product, is becoming a growing cause for delayed immunizations.

Medical providers need to be able to show that delay in vaccine administration is related to non-delivery or insufficient supply of the vaccine. With the proposed changes, primary care providers will be able to show why a vaccine that would be expected to be administered as part of the Advisory Committee on Immunization Practices (ACIP) schedule was not administered.

This proposal was originally presented at the March 2017 C&M meeting. The requestor, the American Academy of Pediatrics, supports the recommendations received during the comment period and a revised proposal is being presented for further consideration.

The following tabular modifications are being requested:

TABULAR MODIFICATIONS

	Z28	Immunization not carried out and underimmunization status
		Includes: vaccination not carried out
		Z28.8 Immunization not carried out for other reason
New code	Z28.83	Immunization not carried out due to vaccine delivery
Add		Lack of availability of vaccine
Add		Delay in delivery of vaccine
Add		Manufacturer delay of vaccine

Infection Following a Procedure

Surgical site infections are commonly classified according to their depth: superficial incisional, deep incisional, and organ/space infection. These categories are consistent with the Centers for Disease Control and Prevention criteria for defining a Surgical Site Infection (SSI).

The Patient Assessment and Outcome Committee of the American Association for the Surgery of Trauma is requesting the following tabular modifications to better distinguish the severity of infections following a procedure.

This topic was presented at the September 2015 and September 2016 C&M meeting. In response to additional public comment, the proposal has been modified and being represented for further consideration. In addition, based on public comment, a separate proposal for new codes at O86.0 Infection of obstetric surgical wound will also be represented.

TABULAR MODIFICATIONS

T81 Complications of procedures, not elsewhere classified

T81.4 Infection following a procedure

Delete	Includes: ~~Intra-abdominal abscess following a procedure~~
Delete	Includes: ~~Postprocedural infection, not elsewhere classified~~
Delete	Includes: ~~Sepsis following a procedure~~
Delete	Includes: ~~Stitch abscess following a procedure~~
Delete	Includes: ~~Subphrenic abscess following a procedure~~
	Includes: Wound abscess following a procedure
	Use additional code to identify infection
	Use additional code (R65.2-) to identify severe sepsis, if applicable
Revise	Excludes~~2~~ 1: Obstetric surgical wound infection (O86.0)
	Postprocedural fever NOS (R50.82)
	Postprocedural retroperitoneal abscess (K68.11)

New code	T81.40	Infection following a procedure, unspecified
New Code	T81.41	Infection following a procedure, superficial incisional surgical site Subcutaneous abscess following a procedure
Add		Stitch abscess following a procedure
New code	T81.42	Infection following a procedure, deep incisional surgical site Intra-muscular abscess following a procedure
New code	T81.43	Infection following a procedure, organ and space surgical site Intra-abdominal abscess following a procedure Subphrenic abscess following a procedure
New code **Add**	T81.44	Sepsis following a procedure **Use additional code to identify the sepsis**
New code	T81.49	Infection following a procedure, other surgical site

K68 Disorders of retroperitoneum

K68.1 Retroperitoneal abscess

K68.11 Postprocedural retroperitoneal abscess

Add Excludes2: Infection following procedure (T81.4-)

Infection of Obstetric Surgical Wound

The American Congress of Obstetricians and Gynecologists (ACOG) is requesting code expansion at code category O86.0 Infection of obstetric surgical wound. It was originally presented at the March 2017 Coordination and Maintenance (C&M) meeting. These changes are shown in bold. This code expansion will align with the proposed new codes at category T81.4 Infection following procedure that is also being represented today.

The code expansion is in response to public comments made at the September 2015 C&M meeting and ACOG is in agreement with the expansion. ACOG proposes the following tabular modifications:

TABULAR MODIFICATION

O86 Other puerperal infections
Use additional code (B95-B97), to identify infectious agent
Excludes2: infection during labor (O75.3)
obstetrical tetanus (A34)

O86.0 Infection of obstetric surgical wound
Infected cesarean delivery wound following delivery
Infected perineal repair following delivery

Add Excludes1: Complications of procedures, not elsewhere classified (T81.4-)
Postprocedural fever NOS (R50.82)
Postprocedural retroperitoneal abscess (K68.11)

New code O86.00 Infection of obstetric surgical wound, unspecified

New code O86.01 Infection of obstetric surgical wound infection, superficial incisional site
Add Subcutaneous abscess following a procedure
Add Stitch abscess following a procedure

New code O86.02 Infection of obstetric surgical wound infection, deep incisional site
Add Intramuscular abscess following a procedure
Add Sub-fascial abscess following a procedure

New code O86.03 Infection of obstetric surgical wound infection, organ and space site
Add Intraabdominal abscess following a procedure
Add Subphrenic abscess following a procedure

New code O86.04 Sepsis following a procedure
Add **Use additional code to identify the sepsis**

New code O86.09 Infection of obstetric surgical wound infection, other **surgical** site

Intrauterine Exposure

The American Academy of Pediatrics and the West Virginia Perinatal Partnership, a statewide organization of over 300 health care professionals and public and private agencies working to improve perinatal health. Working collaborately, they are proposing new codes to identify specific substances known to cause problems and increased health care utilization in the neonatal population. In order to improve the ability to collect data on maternal drug use affecting the newborn, it is being proposed that the P04 code category be expanded.

These new codes will allow for more specificity to determine trends in neonatal outcomes from intrauterine drug exposure. The expansion of the current codes will allow federal and state governments, health care agencies, policy analysts, health care researchers, and payers to track the incidence and costs associated with maternal substance use (including prescription medication) affecting the neonate. Substance use, particularly during pregnancy, is a national crisis requiring state-level tracking and reporting. Accurate and specific ICD-10-CM coding is vital to these efforts.

A complete understanding of the incidence and costs associated with intrauterine exposure is vital to the development of effective interventions. The Protecting our Infants Act of 2015 seeks to address this need by among other things, mandating that the Health and Human Services (HHS) help states improve the availability and quality of data collection and surveillance activities regarding prenatal drug use.

Having the ability to assess intrauterine exposure to specific substances and whether or not exposure led to withdrawal, will allow states to track length of stay, associated costs, and long-term adverse health outcomes. In addition, it will allow for the development of effective treatment interventions based upon which substances the newborn was exposed to and assess regional differences and emerging trends associated with maternal substance use.

Currently state and national agencies and organizations are limited in their attempts to track intrauterine exposure and withdrawal symptom incidents due to specific substance as the current code, P96.1 Neonatal withdrawal symptoms from maternal use of drugs of addition, does not make that distinction.

Although a few states rely on survey data and other forms of self-reporting conducted by hospitals, this approach has several important disadvantages. Often the process is not automated, increasing likelihood of error or underreporting, and the costs associated with length of stay and specific interventions are not included. Given that additional resources are required to design, implement, and maintain alternate reporting systems, these surveillance systems are only available in a limited number of states. As a result, these systems do not allow for national or even regional tracking of intrauterine exposure and subsequently neonatal abstinence syndrome (NAS).

The ICD-9-CM coding structure included codes to indicate intrauterine exposure to a variety of substances. The ICD-9-CM code 760.7x , Noxious influences affecting fetus or newborn via placenta or breast milk, allowed for tracking of exposure to those substances that specifically produce neonatal withdrawal.

For example, ICD-9-CM Code 760.72, Narcotics, indicated the fetus was exposed to narcotics. (Narcotic is a broad term that includes drugs such as opiates and opioids). In ICD-10-CM, this code crosswalks to P04.49, Newborn affected by maternal use of other drugs of addiction. This code does not specify opiates/opioids and may include maternal use of a variety of drugs in the prenatal period.

The requestors are also requesting that a code from P04 category be allowed to be reported with the appropriate withdrawal code from P96 to be able to give a clear picture of a baby in withdrawal and the specific drug causing the withdrawal. This will also allow coding of the specific maternal drug when the newborn is affected (e.g., low birth weight), however, have not been diagnosed with withdrawal.

The American Academy of Pediatrics and the West Virginia Perinatal Partnership are proposing the following codes expansion:

TABULAR MODIFICATIONS

	P04	Newborn affected by noxious substances transmitted via placenta or breast milk
	P04.0	Newborn affected by maternal anesthesia and analgesia in pregnancy, labor and delivery
Revise		Newborn affected by reactions and intoxications from maternal opiates and tranquilizers administered <u>for procedures</u> during <u>pregnancy</u> or labor and delivery
Add		Excludes2: newborn affected by other maternal medication (P04.1-)
New subcategory	P04.1	Newborn affected by other maternal medication
Delete		~~Newborn affected by cancer chemotherapy~~
Delete		~~Newborn affected by cytotoxic drugs~~
Add		Code first withdrawal symptoms from maternal use of drugs of addiction (P96.1) if applicable
Revise		Excludes~~1~~2:maternal anesthesia and analgesia in pregnancy, labor and delivery (P04.0)maternal use of drugs of addiction (P04.4-)

New code	P04.11 Newborn affected by maternal cancer chemotherapy
New code	P04.12 Newborn affected by maternal cytotoxic drugs
New code	P04.13 Newborn affected by maternal use of anticonvulsants
New code	P04.14 Newborn affected by maternal use of opiates
New code	P04.15 Newborn affected by maternal use of antidepressants
New code	P04.16 Newborn affected by maternal use of amphetamines
New code	P04.17 Newborn affected by maternal use of sedative-hypnotics
New code	P04.1A Newborn affected by maternal use of anxiolytics
New code	P04.18 Newborn affected by other maternal medication
New code	P04.19 Newborn affected by maternal use of unspecified medication
New subcategory	P04.4 Newborn affected by maternal use of drugs of addiction
New code	P04.40 Newborn affected by maternal use of unspecified drugs of addiction
New Code	P04.42 Newborn affected by maternal use of hallucinogens
Add	Excludes2: newborn affected by other maternal medication (P04.1-)
Delete	~~withdrawal symptoms from maternal use of drugs of addiction (P96.1)~~
New subcategory	P04.8 Newborn affected by other maternal noxious substances
New code	P04.81 Newborn affected by maternal use of cannabis

Mental Health Screening: Depression and Other

Mental health screening, specifically depression, is now being routinely recommended by both government and non-government entities responsible for developing preventive measures and standards. In addition, the Healthcare Effectiveness Data and Information Set (HEDIS) includes the rate of depression screening performed on adolescents and adults as part of its measures. HEDIS is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service.

It is important to have the ability to report the appropriate ICD-10-CM code(s) to differentiate between depression screening and perinatal or maternal depression screening. This data is vital to show that a physician is following key preventive recommendations as well as tracking for HEDIS.

In response to the request from the American Academy of Pediatrics, NCHS proposes to reactivate WHO ICD-10 code Z13.3, Special screening examination for mental and behavioral disorders, with further specificity to meet HEDIS requirements.

The following tabular modifications are requested:

TABULAR MODIFCATION

	Z13	Encounter for screening for other disease and disorders
New subcategory		Z13.3 Encounter for screening examination for mental health and behavioral disorders
New code		Z13.30 Encounter for screening examination for mental health and behavioral disorders, unspecified
New code		Z13.31 Encounter for screening for depression
Add		Encounter for screening for depression for child or adolescent
Add		Encounter for screening for depression, adult
New code		Z13.32 Encounter for screening for maternal depression
Add		Encounter for screening for perinatal depression
New code		Z13.39 Encounter for screening examination for other mental health and behavioral disorders
Add		Encounter for screening for alcoholism
Add		Encounter for intellectual disabilities

Myalgia of mastication and auxiliary muscles

Myalgia of the mastication and auxiliary muscles are the most common complaint of patients who report with temporomandibular dysfunction. There are four muscles of mastication – the masseter, temporalis, medial pterygoid and lateral pterygoid. These muscles of mastication are associated with movements of the jaw (temporomandibular joint).

An estimated 60 -70% of presenting patients have some degree of myalgia even if they also have a true internal derangement. The issue is to initially ferret out the myalgia and then treat the internal derangement via surgery if necessary. The differential diagnosis includes a variety of both malignant and non-malignant conditions.

The American Association of Oral and Maxillofacial Surgeons (AAOMS) are requesting new codes for specific areas of pain in order to help provide an accurate diagnosis or diagnoses. The specific area where the pain is coming from helps in determining the treatment sequence since a right temporalis pain could be a trigger point of a neurological problem.

AAOMS is requesting the following new codes identify these conditions in ICD-10-CM.

TABULAR MODIFICATIONS

M79 Other and unspecified soft tissue disorders, not elsewhere classified
M79.1 Myalgia
Myofascial pain syndrome
Excludes1**:** fibromyalgia (M79.7)
myositis (M60.-)

New code M79.10 Myalgia, unspecified site

New subcategory M79.11 Myalgia of mastication muscle

New sub-subcategory M79.11A Myalgia of masseter muscle

New code M79.11A1 Myalgia, right masseter
New code M79.11A2 Myalgia, left masseter
New code M79.11A3 Myalgia, bilateral masseter
New code M79.11A9 Myalgia, unspecified masseter

New sub-subcategory M79.11B Myalgia of temporalis muscle
Add Myalgia, temporalis tendon

New code M79.11B1 Myalgia, right temporalis
New code M79.11B2 Myalgia, left temporalis
New code M79.11B3 Myalgia, bilateral temporalis

New code	M79.11B9	Myalgia, unspecified temporalis
New sub-subcategory	M79.11C	Myalgia of medial pterygoid muscle
Add		Myalgia, internal pterygoid muscle
New code	M79.11C1	Myalgia, right medial pterygoid
New code	M79.11C2	Myalgia, left medial pterygoid
New code	M79.11C3	Myalgia, bilateral medial pterygoid
New code	M79.11C9	Myalgia, unspecified medial pterygoid
New sub-subcategory	M79.11D	Myalgia of lateral pterygoid muscle
Add		Myalgia, external pterygoid muscle
New code	M79.11D1	Myalgia, right lateral pterygoid
New code	M79.11D2	Myalgia, left lateral pterygoid
New code	M79.11D3	Myalgia, bilateral lateral pterygoid
New code	M79.11D9	Myalgia, unspecified lateral pterygoid
New subcategory	M79.12	Myalgia of auxiliary muscles, head and neck
New sub-subcategory	M79.12A	Myalgia of splenius capitis
New code	M79.12A1	Myalgia, right splenius capitis
New code	M79.12A2	Myalgia, left splenius capitis
New code	M79.12A3	Myalgia, bilateral splenius capitis
New code	M79.12A9	Myalgia, unspecified splenius capitis
New sub-subcategory	M79.12B	Myalgia of Sternocleidomastoid
New code	M79.12B1	Myalgia, right sternocleidomastoid
New code	M79.12B2	Myalgia, left sternocleidomastoid
New code	M79.12B3	Myalgia, bilateral sternocleidomastoid
New code	M79.12B9	Myalgia, unspecified sternocleidomastoid
New sub-subcategory	M79.12C	Myalgia of Trapezius
New code	M79.12C1	Myalgia, right trapezius
New code	M79.12C2	Myalgia, left trapezius
New code	M79.12C3	Myalgia, bilateral trapezius
New code	M79.12C9	Myalgia, unspecified trapezius
New code	M79.19	Myalgia, other site

Neonatal Metabolic Disturbances

Neonatal metabolic disturbances are transitory conditions that occur during birth or shortly thereafter. ICD-10-CM codes that are currently found in Chapter 4 Endocrine, Nutritional and Metabolic Diseases (E00-E89) do not adequately reflect metabolic disturbances in the major serum electrolytes (sodium, potassium, chloride and bicarbonate) that are specific to the neonate.

Currently codes for disturbances in sodium balance and disturbances in potassium balance that are found in Chapter 16 Certain Conditions Originating in the Perinatal Period (P00-P96), do not differentiate between hyper and hyponatremia or, hyper and hypokalemia. In addition, there are no codes for abnormal serum concentrations of chloride or bicarbonate.

These conditions have different etiologies, consequences, and treatment with potentially a different level of urgency. Fluid management is an important component of treatment and varies greatly between these conditions. Sometimes medications are used depending on which condition is present. Newborns may experience both hyper and hyponatremia or hyper and hypokalemia during their hospital course; the same is true for high or low serum chloride and bicarbonate concentrations.

The American Academy of Pediatrics respectfully requests addition of codes in category P74, Other transitory neonatal electrolyte and metabolic disturbances, to specifically identify these metabolic disturbances.

The following tabular modifications are being requested:

TABULAR MODIFICATIONS

P74 Other transitory neonatal electrolyte and metabolic disturbances

P74.2 Disturbances of sodium balance of newborn

New code	P74.20 Disturbances of sodium balance of newborn, unspecified
New code	P74.21 Hypernatremia of newborn
New code	P74.22 Hyponatremia of newborn
New code	P74.29 Disturbances of other sodium balance of newborn

P74.3 Disturbances of potassium balance of newborn

New code	P74.30 Disturbances of potassium balance of newborn, unspecified
New code	P74.31 Hyperkalemia of newborn
New code	P74.32 Hypokalemia of newborn
New code	P74.39 Disturbances of other potassium balance of newborn

	P74.4 Other transitory electrolyte disturbances of newborn
New Code	P74.40 Alkalosis of newborn
Add	Includes hyperbicarbonatemia
New sub-subcategory	P74.41 Disturbances of chlorine balance of newborn
New code	P74.411 Hyperchloremia of newborn
Add	Hyperchloremic metabolic acidosis
Add	Excludes2: late metabolic acidosis of the newborn
New code	P74.412 Hypochloremia of newborn
New code	P74.419 Disturbances of chlorine balance of newborn, unspecified

Neoplasm unspecified behavior of testis

Patients may present with a growth or mass of the testicle detected by examination or by an imaging study performed for genitourinary or non-genitourinary reasons, and further testing and/or procedures would be indicated. Such testing may include further imaging or lab tests, obtaining tissue by biopsy for diagnosis, or performing invasive surgery. The differential diagnosis of a neoplasm of the testicle includes a variety of both malignant and non-malignant conditions.

Currently in ICD-10-CM, there are no unique codes for neoplasm of unspecified behavior of testicle.

The American Urological Association (AUA) is requesting the following new codes to accurately describe the situation where a neoplasm is discovered on the testicle and tissue has not yet been obtained to make a diagnosis.

TABULAR MODIFICATIONS

D49 Neoplasms of unspecified behavior

D49.5 Neoplasm of unspecified behavior of other genitourinary organs

New sub-subcategory	D49.52	Neoplasm of unspecified behavior of testis, testes	
New code		D49.521	Neoplasm of unspecified behavior of right testis
New code		D49.522	Neoplasm of unspecified behavior of left testis
New code		D49.523	Neoplasm of unspecified behavior of testes, bilateral
New code		D49.529	Neoplasm of unspecified behavior of unspecified testis

Obsessive-compulsive disorder

The American Psychiatric Association (APA) is requesting that the 4th character for code category F42 Obsessive-compulsive disorder (i.e., F42.2 for Mixed obsessional thoughts and acts, F42.3 for Hoarding disorder, F42.4 for Excoriation disorder, F42.8 for Other obsessive-compulsive disorder, and F42.9 for Obsessive-compulsive disorder), which were implemented October 1, 2016 at APA's request, be removed from ICD-10-CM and that new codes be assigned for Hoarding disorder and excoriation disorder.

In the World Health Organization (WHO) ICD-10, F42 Obsessive-compulsive disorder has three subcategories: F42.0 Predominantly obsessional thoughts or ruminations, F42.1 Predominantly compulsive acts, and F42.2 Mixed obsessional thoughts and acts. During the development on ICD-10-CM in the 1990's, these three subtypes were not implemented in ICD-10-CM given the lack of clinical need to provide subtypes for OCD based on whether obsessions or compulsions predominate. As part of its effort to request new codes for categories included in DSM-5, APA requested new codes for Hoarding disorder (F42.3) and Excoriation disorder (F42.4) as well as requesting a reactivation of F42.2 Mixed obsessional thoughts and acts from the WHO ICD-10, which would then be used in DSM-5 as the code for Obsessive-compulsive disorder instead of F42. All of these changes were implemented in the FY 2017 ICD-10-CM. The new codes for Hoarding disorder (F42.3) and Excoriation disorder (F42.4), however, turned out to be problematic since Hoarding disorder and Excoriation disorder are not "subtypes" of OCD, as is implied in their being 4th digit codes under Obsessive-compulsive disorder. In fact, these disorders are separate and distinct from Obsessive-compulsive disorder. Moreover, using F42.2 for Obsessive-compulsive disorder was problematic because not all cases of Obsessive-compulsive disorder are characterized by a mix of obsessions and compulsions. There are cases with only obsessions as well as only compulsions.

At the September 2016 C&M meeting, APA presented a proposal that would have changed F42 to be Obsessive-compulsive and related disorders and renamed F42.2 to be Obsessive-compulsive disorder. These changes would have fixed the problem since both Hoarding disorder and Excoriation disorder are subcategories of Obsessive-compulsive and related disorders. This proposal, however, was rejected because renaming the WHO ICD-10 category F42 and code F42.2 is not allowed and inconsistent with WHO ICD-10 codes.

APA is now requesting that F42 revert to what it was in the 2016 ICD-10-CM and that new codes be created for Hoarding disorder and Excoriation disorder. Given that Excoriation disorder (also known as skin picking disorder) is closely related to F63.3 Trichotillomania (hair-pulling disorder), we are requesting that it be placed adjacent to Trichotillomania with the code F63.4. Given that there is no specific three character ICD-10-CM category that is appropriate for the placement of Hoarding Disorder, we are requesting that Hoarding Disorder be placed under F48, Other nonpsychotic mental disorders, and assigned the new code, F48.3. APA is also requesting that two additional inclusion terms be added to F48.8 for DSM-5 compatibility: Other obsessive-compulsive and related disorder and unspecified obsessive-compulsive and related disorder.

TABULAR MODIFICATIONS

F42 Obsessive-compulsive disorder

Add Anacastic neurosis

Add Obsessive-compulsive neurosis

Excludes2: obsessive-compulsive personality (disorder) (F60.5)
obsessive-compulsive symptoms occurring in depression (F32-F33)
obsessive-compulsive symptoms occurring in schizophrenia (F20.-)

Delete ~~F42.2 Mixed obsessional thoughts and acts~~

Delete ~~F42.3 Hoarding disorder~~

Delete ~~F42.4 Excoriation (skin-picking) disorder~~

Delete ~~Excludes1: factitial dermatitis (L98.1)~~

Delete ~~other specified behavioral and emotional disorders with onset usually occurring in early childhood and adolescence (F98.8)~~

Delete ~~F42.8 Other obsessive-compulsive disorder~~

Delete ~~Anancastic neurosis~~

Delete ~~Obsessive-compulsive neurosis~~

Delete ~~F42.9 Obsessive-compulsive disorder, unspecified~~

F48 Other nonpsychotic mental disorders

F48.1 Depersonalization-derealization syndrome

F48.2 Pseudobulbar affect

New code F48.3 Hoarding Disorder

F48.8 Other specified nonpsychotic mental disorders
Dhat syndrome
Neurasthenia
Occupational neurosis, including writer's cramp
Psychasthenia
Psychasthenic neurosis
Psychogenic syncope

Add Other Obsessive-compulsive and related disorder

Add Unspecified Obsessive-compulsive and related disorder

F63 Impulse disorder
Excludes2: habitual excessive use of alcohol or psychoactive substances (F10-F19)
impulse disorders involving sexual behavior (F65.-)

New code F63.4 Excoriation (skin-picking) disorder
Add Excludes1: factitial dermatitis (L98.1)

Osteoporosis Related Pathological Fracture of jaw

The American Association of Oral and Maxillofacial Surgeons (AAOMS) is proposing the creation of new codes for a pathological fracture of the jaw due to age-related osteoporosis and pathological fracture of the jaw due to drug-induced osteoporosis**.** While there is a code for multiple types of fractures within each subcategory, fracture of the jaw is not listed. The closest entry is directed to code M80.00, Age-related osteoporosis with current pathological fracture, unspecified site and code M80.80, Other osteoporosis with current pathological fracture, unspecified site.

The AAOMS is requesting the following tabular changes in order to identify these conditions.

TABULAR MODIFICATIONS

	M80	Osteoporosis with current pathological fracture
	M80.0	Age-related osteoporosis with current pathological fracture
	M80.08	Age-related osteoporosis with current pathological fracture, vertebrae
New sub-subcategory	M80.0C	Age-related osteoporosis with current pathological fracture, mandible
New code	M80.0C1	Age-related osteoporosis with current pathological fracture, right mandible
New code	M80.0C2	Age-related osteoporosis with current pathological fracture, left mandible
New code	M80.0C3	Age-related osteoporosis with current pathological fracture, bilateral mandible
New code	M80.0C9	Age-related osteoporosis with current pathological fracture, unspecified mandible
Add		Jaw NOS
New sub-subcategory	M80.0D	Age-related osteoporosis with current pathological fracture, maxilla
New code	M80.0D1	Age-related osteoporosis with current pathological fracture, right maxilla
New code	M80.0D2	Age-related osteoporosis with current pathological fracture, left maxilla
New code	M80.0D3	Age-related osteoporosis with current pathological fracture, bilateral maxilla
New code	M80.0D9	Age-related osteoporosis with current pathological fracture, unspecified maxilla

M80.8 Other osteoporosis with current pathological fracture

M80.88 Other osteoporosis with current pathological fracture, vertebrae

New sub-subcategory M80.8C Other osteoporosis with current pathological fracture, mandible

New code M80.8C1 Other osteoporosis with current pathological fracture, right mandible

New code M80.8C2 Other osteoporosis with current pathological fracture, left mandible

New code M80.8C3 Other osteoporosis with current pathological fracture, bilateral mandible

New code M80.8C9 Other osteoporosis with current pathological fracture, unspecified mandible

Add Jaw NOS

New sub-subcategory M80.8D Other osteoporosis with current pathological fracture, maxilla

New code M80.8D1 Other osteoporosis with current pathological fracture, right maxilla

New code M80.8D2 Other osteoporosis with current pathological fracture, left maxilla

New code M80.8D3 Other osteoporosis with current pathological fracture, bilateral maxilla

New code M80.8D9 Other osteoporosis with current pathological fracture, unspecified maxilla

Osteoporosis Related Pathological Fracture of Rib and Pelvis

Pathological fractures of the ribs and of the pelvis are fairly common with the elderly, especially with those who have chronic disease comorbidities such as neoplastic disease and osteoporosis. It is being proposed to create new codes for age related pathological fractures of the rib(s) and pelvis due to osteoporosis. This revised proposal is based on public comments received following the March 2017 Coordination and Maintenance meeting.

The codes in the M84.6- category, Pathological fracture in other disease, specifically exclude pathological fractures caused by osteoporosis. Currently, the closest entry for coding is directed to code M80.00, Age-related osteoporosis with current pathological fracture, unspecified site and code M80.80, Other osteoporosis with current pathological fracture, unspecified site.

DecisionHealth, a home health consulting company, is requesting the following tabular changes in order to capture these conditions.

TABULAR MODIFICATIONS

M80 Osteoporosis with current pathological fracture

M80.0 Age-related osteoporosis with current pathological fracture

M80.08 Age-related osteoporosis with current pathological fracture, vertebrae
New code M80.09 Age-related osteoporosis with current pathological fracture, other site
New code M80.0A Age-related osteoporosis with current pathological fracture, rib(s)
New code M80.0B Age-related osteoporosis with current pathological fracture, pelvis
Add Ischium
Add Ilium
Add Pubis

M80.8 Other osteoporosis with current pathological fracture

M80.88 Other osteoporosis with current pathological fracture, vertebrae
New code M80.89 Other osteoporosis with current pathological fracture, other site
New code M80.8A Other osteoporosis with current pathological fracture, rib(s)
New code M80.8B Other osteoporosis with current pathological fracture, pelvis
Add Ischium

Add	Ilium
Add	Pubis

Other Doubling of Uterus

The American Congress of Obstetricians and Gynecologists (ACOG) is requesting additional specificity and an expansion of the codes to report "other doubling of the uterus" to include septate uterus. The septate uterus occurs in two versions; partial septate uterus and complete septate uterus.

ACOG is requesting new codes to specifically identify these congenital malformations by expanding the Q51 code category.

ACOG proposes the following tabular modifications:

TABULAR MODIFICATIONS

Q51	Congenital malformations of uterus and cervix	
Q51.2	Other doubling of uterus Doubling of uterus NOS	
Revise	Septate uterus~~, complete or partial~~	
New code	Q51.20	Other doubling of uterus, unspecified
Add		Septate uterus, unspecified
New code	Q51.21	Other doubling of uterus, complete
Add		Septate uterus, complete
New code	Q51.22	Other doubling of uterus, partial
Add		Septate uterus, partial
New code	Q51.28	Other doubling of uterus, other specified
Add		Septate uterus, other specified
New code	Q51.29	Other doubling of uterus, unspecified
Add		Septate uterus, unspecified

Phlebitis and Thrombophlebitis

Phlebitis means inflammation of a vein. Thrombophlebitis refers to a blood clot causing the inflammation. Phlebitis can be superficial or deep within the tissues beneath the skin. Superficial phlebitis is phlebitis that is in a superficial vein under the surface of the skin. Deep vein thrombophlebitis refers to a blood clot causing phlebitis in the deeper veins. Deep vein thrombophlebitis is also referred to as deep venous thrombophlebitis or deep vein thrombosis (DVT).

Superficial thrombophlebitis is a common inflammatory-thrombotic disorder in which a thrombus develops in a vein located near the surface of the skin. Superficial thrombophlebitis usually occurs in the lower extremities. It can also develop anywhere that medical interventions occur, such as in the arm or neck (external jugular vein) if it has been used for an infusion site. Superficial thrombophlebitis of the upper extremities usually occurs at infusion sites or sites of trauma.

The following new codes are being proposed to restore the detail that was lost in transition from ICD-9-CM to ICD-10-CM for reporting upper extremity conditions.

TABULAR MODIFICATIONS

I80 Phlebitis and thrombophlebitis

New subcategory I80.8 Phlebitis and thrombophlebitis of other sites

New sub-subcategory I80.81 Phlebitis and thrombophlebitis of superficial vessels of upper extremity

New code I80.811 Phlebitis and thrombophlebitis of superficial vessels of right upper extremity

New code I80.812 Phlebitis and thrombophlebitis of superficial vessels of left upper extremity

New code I80.813 Phlebitis and thrombophlebitis of superficial vessels of upper extremities, bilateral

New code I80.819 Phlebitis and thrombophlebitis of superficial vessels of unspecified upper extremity

New sub-subcategory I80.82 Phlebitis and thrombophlebitis of deep vessels of upper extremity

New code I80.821 Phlebitis and thrombophlebitis of deep vessels of right upper extremity

New code	I80.822	Phlebitis and thrombophlebitis of deep vessels of left upper extremity
New code	I80.823	Phlebitis and thrombophlebitis of deep vessels of upper extremities, bilateral
New code	I80.829	Phlebitis and thrombophlebitis of deep vessels of unspecified upper extremity
New code	I80.89	Phlebitis and thrombophlebitis of other sites

Plasminogen Deficiency

Plasminogen is an inactive proenzyme that naturally circulates in the blood plasma. The active enzyme derived from it, plasmin, plays key roles in fibrinolysis, tissue remodeling, and wound healing. Plasminogen deficiency is a rare genetic disorder caused by the absence or dysfunction of plasminogen, due to mutations in the PLG gene. There are two types of plasminogen deficiency. Plasminogen deficiency type I is a quantitative deficiency, while type II is a qualitative defect.

Clinical manifestations of plasminogen deficiency are related to an inability to remove fibrin deposits, related to extravascular clots. The fibrin deposits become organized, and form "ligneous" (wood-like) lesions, which may get progressively larger. Depending on the site of these lesions, there can be a range of different presentations. The most common and hallmark finding is fibrin deposits in the conjunctiva, ligneous conjunctivitis. This can cause vision loss if the cornea is involved. Fibrin deposits in the ventricular system of the brain can lead to congenital obstructive hydrocephalus. Ligneous otitis media may cause hearing loss. Bronchotracheal obstructive lesions may lead to respiratory insufficiency. Lesions in the genitourinary tract may lead to ureteric obstruction. Ligneous vaginitis and uterine lesions may lead to infertility. Impaired wound healing is also associated with plasminogen deficiency.

Diagnosis of plasminogen deficiency is by laboratory testing. Plasminogen deficiency type I is diagnosed based on low levels of plasminogen activity, and low antigen levels. Plasminogen deficiency type II is diagnosed when there are low levels of plasminogen activity, but normal antigen levels.

It has been requested that a specific ICD-10-CM code be added for plasminogen deficiency, along with notes on additionally coding certain of the potential manifestations.

References

Mehta R, Shapiro AD. Plasminogen deficiency. Haemophilia. 2008 Nov;14(6):1261-8. https://doi.org/10.1111/j.1365-2516.2008.01825.x

Schuster V, Hügle B, Tefs K. Plasminogen deficiency. J Thromb Haemost. 2007 Dec; 5(12):2315-22. Epub 2007 Sep 26. https://doi.org/10.1111/j.1538-7836.2007.02776.x

TABULAR MODIFICATIONS

E88 Other and unspecified metabolic disorders

E88.0 Disorders of plasma-protein metabolism, not elsewhere classified

New code E88.02 Plasminogen deficiency
Add Dysplasminogenemia
Add Hypoplasminogenemia
Add Code also, if applicable, ligneous conjunctivitis (H10.51)
Add Use additional code for associated findings, such as:
Add hydrocephalus (G91.4)
Add ligneous conjunctivitis (H10.51)
Add otitis media (H67)
Add respiratory disorder related to plasminogen deficiency (J99)

G91 Hydrocephalus

G91.4 Hydrocephalus in diseases classified elsewhere
Code first underlying condition, such as:
Add plasminogen deficiency (E88.02)

H10 Conjunctivitis

H10.5 Blepharoconjunctivitis

H10.51 Ligneous conjunctivitis
Add Code also underlying condition if known, such as:
Add plasminogen deficiency (E88.02)

H67 Otitis media in diseases classified elsewhere
Code first underlying disease, such as:
Add plasminogen deficiency (E88.02)

J99 Respiratory disorders in diseases classified elsewhere
Code first underlying disease, such as:
Add plasminogen deficiency (E88.02)

Postpartum Depression & Postpartum Psychosis

Postpartum depression (PPD) typically emerges over the first two to three postpartum months but may occur at any point after delivery. Some women actually note the onset of milder depressive symptoms during pregnancy. Postpartum depression is clinically indistinguishable from depression occurring at other times during a woman's life. A few of the symptoms of postpartum depression include: depressed or sad mood, tearfulness, loss of interest in usual activities, feelings of guilt, worthlessness or incompetence, fatigue, change in appetite, and suicidal thoughts.

Significant anxiety symptoms may occur. Generalized anxiety is common but women may also develop panic attacks. It may be difficult to detect postpartum depression because many of the symptoms used to diagnosis depression (i.e., sleep and appetite disturbance, fatigue) also occur in postpartum women in the absence of depression. The Edinburgh Postnatal Depression Scale (a screening tool that aims to identify women who may benefit from follow-up care, such as mental health assessment, which may lead to a diagnosis based on accepted diagnostic criteria.

Postpartum Psychosis is the most severe form of postpartum psychiatric illness. It is a rare event that occurs in approximately 1-2 per 1000 women after childbirth. Its presentation is often dramatic with onset of symptoms as early as the first 48 to 72 hours after delivery. The majority of women with puerperal psychosis develop symptoms within the first two postpartum weeks. Women with this disorder exhibit a rapidly shifting depressed or elated mood disorientation or confusion and erratic or disorganized behavior. Delusional beliefs are common and often center on the infant. Auditory hallucinations that instruct the mother to harm herself or her infant may also occur.

Clinically these two conditions have significant different presentations and treatment guidelines. Currently in ICD-10-CM both of these conditions are found in the same code. It is being proposed to revise the current code title and specific codes for these clinical conditions. The American Psychiatric Association (APA) has reviewed and support this proposal.

TABULAR MODIFICATIONS

Revise	F53	~~Puerperal psychosis~~ Mental and behavioral disorders associated with the puerperium, not elsewhere classified
Revise		Excludes~~1~~ 2: mood disorders with psychotic features (F30.2, F31.2, F31.5, F31.64, F32.3, F33.3) postpartum dysphoria (O90.6) psychosis in schizophrenia, schizotypal, delusional, and other psychotic disorders (F20-F29

New code	F53.0	Postpartum depression
Add		Postpartum depression, NOS
Add		Postnatal depression, NOS

New code	F53.1	Puerperal psychosis
Add		Postpartum psychosis
Add		Puerperal psychosis, NOS

Pressure ulcer of mucosal membrane by site

There is currently no indexing for pressure ulcers or sores involving mucosal membranes. The available options under "ulcer, pressure," "sore, pressure," etc., include ankle, back, buttock, coccyx, elbow, face, head, heel, hip, and sacral, but these are all skin sites, not mucous membranes.

AHRQ reports that some coders are using "specified site NEC" (L89.89-) to describe pressure sores involving mucous membranes, but other coders are concerned that this code is in Chapter 12, Diseases of the skin and subcutaneous tissue, which may not be an appropriate for conditions involving mucous membranes. The index appears to refer users to non-specific body part diagnoses such as K13.0 (ulcer, lip), K06.8 (ulcer, gum), K62.6 (ulcer, anorectal), J34.0 (ulcer, nose), N34.2 (ulcer, urethra), N76.5 (ulcer, vagina), and K12.1 (ulcer, oral mucosa), but none of these codes clearly captures iatrogenic pressure ulcers (injuries).

AHRQ has proposed the creation of new codes at L89.82, Pressure ulcer of other site, to identify mucosal membrane pressure ulcers of specific sites designated at the 6th character. AHRQ believes that unique codes are needed to capture this important information.

TABULAR MODIFICATIONS

L89 Pressure ulcer

L89.8 Pressure ulcer of other site

New subcategory	L89.82	Pressure ulcer of mucosal membrane
New code	L89.821	Pressure ulcer of nasal mucosal membrane
New code	L89.822	Pressure ulcer of oral (mouth) mucosal membrane Pressure ulcer of gum mucosal membrane Pressure ulcer of lip mucosal membrane
New code	L89.823	Pressure ulcer of gastrointestinal mucosal membrane Pressure ulcer of rectum and anus mucosal membrane
New code	L89.824	Pressure ulcer of urethral mucosal membrane
New code	L89.825	Pressure ulcer of vaginal and vulvar mucosal membrane
New code	L89.829	Pressure ulcer of other and unspecified mucosal membrane

Primary Sclerosing Cholangitis (PSC)

Primary sclerosing cholangitis (PSC) is a rare, chronic and progressive bile duct disease that damages the bile ducts inside and outside the liver. With PSC, bile ducts are inflamed, and the inflammation leads to scarring and narrowing (sclerosing) of the affected ducts. Eventually, blockages may occur. As the scarring blocks more and more ducts, bile becomes trapped in the liver. This damages the liver and can result in fibrosis and cirrhosis of the liver and liver failure. There are no treatments to slow down disease progression and no cure for PSC other than liver transplantation.

PSC is the least common of the autoimmune liver diseases, yet more patients are transplanted every year for PSC than for either of the other autoimmune liver diseases, and at a younger age. PSC is a rare disease that predominantly affects 30 to 40-year-old men. However, PSC also occurs in children of any age, women, and the elderly. PSC affects about twice as many men as women. Over 75 percent of PSC patients have inflammatory bowel disease (IBD). The prevalence of PSC increased in patients with ulcerative colitis About 43 percent do not have any symptoms when diagnosed, and diagnosis is made through a combination of blood tests and imaging; e.g., an estimated 1 in 10,000 people have primary sclerosing cholangitis, and the condition is diagnosed in approximately 1 in 100,000 people per year worldwide https://ghr.nlm.nih.gov/condition/primary-sclerosing-cholangitis#statistics.

Close monitoring of PSC patients is vital. The colon cancer risk, which increases with ulcerative colitis, is multiplied with PSC-IBD overlap and requires close annual monitoring. Moreover, with PSC, the risk of bile duct cancer (cholangiocarcinoma) increases. Individuals with PSC can occasionally develop abdominal pain and fever, which may suggest infection of the bile ducts called cholangitis. Although the latter can be treated with antibiotics, no currently known treatment has been shown to slow the progression or cure PSC. There are, however, several clinical trials underway that aim to slow progression of liver disease and reverse liver damage.

Primary sclerosing cholangitis (PSC) is currently coded to K83.0, Cholangitis. This code applies not only to PSC, but also to a wide variety of related diseases including, but not limited to bacterial cholangitis, ascending cholangitis, recurrent cholangitis, stenosis and suppurative cholangitis. It is proposed to create a specific code for PSC. This can potentially help with tracking patients, and support research to track outcomes, and thus help to enable better understanding of and support finding treatments for this disease. This proposal is submitted at the request of the PSC Partners Seeking a Cure and Dr. Christopher Bowlus, a PSC specialist at the University of California Davis.

1Lars Aabakken, Tom H. Karlsen et al. “Role of endoscopy in primary sclerosing cholangitis: European Society of Gastrointestinal Endoscopy (ESGE) and European Association for the Study of the Liver (EASL) Clinical Guidelines,” 2017. http://dx.doi.org/10.1055/s-0043-107029 Published online: 2017 | Endoscopy © Georg Thieme Verlag KG Stuttgart. New York ISSN 0013-726X This Guideline was published simultaneously in the journals Endoscopy and Journal of Hepatology, 2017.

TABULAR MODIFICATIONS

K83 Other diseases of biliary tract

K83.0 Cholangitis

Delete	~~Ascending cholangitis~~
Delete	~~Cholangitis NOS~~
Delete	~~Primary cholangitis~~
Delete	~~Recurrent cholangitis~~
Delete	~~Sclerosing cholangitis~~
Delete	~~Secondary cholangitis~~
Delete	~~Stenosing cholangitis~~
Delete	~~Suppurative cholangitis~~

New Code	K83.01 Primary Sclerosing Cholangitis

New Code	K83.09 Other Cholangitis
Add	Ascending cholangitis
Add	Cholangitis NOS
Add	Primary cholangitis NOS
Add	Recurrent cholangitis
Add	Sclerosing cholangitis NOS
Add	Secondary (sclerosing) cholangitis
Add	Stenosing cholangitis
Add	Suppurative cholangitis

Tarlov perineural cyst

Tarlov perineural cysts are cerebrospinal fluid-filled sacs that most often occur in the dorsal nerve root ganglion of the nerve root sheath, especially in the sacral spine in 95% of reported cases. Multiple systems symptomatology can occur depending upon the size and specific location of the cyst and due to progressive nerve damage and organ dysfunction. Individuals may also be affected by multiple cysts of varying size in other sections of the spine, with less prevalence (Cervical 3%, Thoracic and Lumbar 6%); 11% of reported cases have cysts imaged in more than one section of the spine. Symptoms caused by Tarlov perineural cysts include pain in the area of the affected nerves, paresthesias (numbness, burning, tingling and altered sensation), severe muscle spasms and cramping, leading to muscle atrophy, chronic headaches, and bladder, bowel and sexual dysfunction. The exact cause of Tarlov cysts is unknown; however, there is some clinical evidence that symptoms developed following trauma, and possible connective tissue disorders (Marfan's, Ehlers-Danlos, Loeys-Dietz, Lupus, Sjogren's, etc.) that predispose the patient to developing this type of spinal nerve root cyst.

These cysts often go unrecognized or misdiagnosed, therefore, determining their true frequency in the general population is difficult (NORD). Diagnosis of Tarlov perineural cyst is best confirmed by spine MRI imaging. In some cases, a diagnosis of a Tarlov perineural cyst is made incidentally through MRI scan investigation undertaken for other reasons including pelvic pain, hip pain, abdominal pain, external genitalia and rectal pain, which can also be symptoms of Tarlov perineural cysts. In looking at incidental findings on MRI of the lumbar spine, researchers have reported finding Tarlov cysts with an incidence ranging from about 1 to 5% (Lucantoni 2011).

The requestor proposes the following new codes to identify these conditions in ICD-10-CM.

References
Tarlov Cyst Foundation info. https://www.tarlovcystfoundation.org/info/

National Institutes of Health (NIH) Genetic and Rare Disease Information Center (GARD) on Tarlov cysts. https://rarediseases.info.nih.gov/diseases/9258/tarlov-cysts

National Organization for Rare Disorders (NORD) on Tarlov cysts. https://rarediseases.org/rare-diseases/tarlov-cysts/

Lucantoni C, Than KD, Wang AC, et al. Tarlov cysts: a controversial lesion of the sacral spine. Neurosurg Focus. 2011 Dec;31(6):E14. http://thejns.org/doi/pdf/10.3171/2011.9.FOCUS11221

TABULAR MODIFICATIONS

	G54	Nerve root and plexus disorders
New subcategory	G54.8	Other nerve root and plexus disorders
New code	G54.81	Tarlov perineural cyst
New code	G54.89	Other nerve root and plexus disorder

Temporomandibular Joint Disorders

The American Association of Oral and Maxillofacial Surgeons (AAOMS) is proposing the creation of new codes for common temporomandibular joint (TMJ) disorders affecting a large cross section of patients. Dysfunction of the TMJ can cause severe pain and lifestyle limitations. The exact cause of a person's TMJ disorder is often difficult to determine and may be due to a combination of problems, such as arthritis or jaw injury.

The AAOMS is requesting the following tabular changes in order to better identify these conditions.

TABULAR MODIFICATIONS

M05 Rheumatoid arthritis with rheumatoid factor

M05.8 Other rheumatoid arthritis with rheumatoid factor

New Sub-subcategory — M05.8A Other rheumatoid arthritis with rheumatoid factor, temporomandibular joint

New code — M05.8A1 Other rheumatoid arthritis with rheumatoid factor, right temporomandibular joint

New code — M05.8A2 Other rheumatoid arthritis with rheumatoid factor, left temporomandibular joint

New code — M05.8A3 Other rheumatoid arthritis with rheumatoid factor, bilateral temporomandibular joint

New code — M05.8A9 Other rheumatoid arthritis with rheumatoid factor, unspecified temporomandibular joint

M06 Other rheumatoid arthritis

M06.0 Rheumatoid arthritis without rheumatoid factor

New sub-subcategory — M06.0A Rheumatoid arthritis without rheumatoid factor, temporomandibular joint

New code — M06.0A1 Rheumatoid arthritis without rheumatoid factor, right temporomandibular joint

New code — M06.0A2 Other rheumatoid arthritis without rheumatoid factor, left temporomandibular joint

New code	M06.0A3	Other rheumatoid arthritis without rheumatoid factor, bilateral temporomandibular joint
New code	M06.0A9	Other rheumatoid arthritis without rheumatoid factor, unspecified temporomandibular joint

M06.8 Other specified rheumatoid arthritis

New sub-subcategory	M06.8A	Other specified rheumatoid arthritis, temporomandibular joint
New code	M06.8A1	Other specified rheumatoid arthritis, right temporomandibular joint
New code	M06.8A2	Other specified rheumatoid arthritis, left temporomandibular joint
New code	M06.8A3	Other specified rheumatoid arthritis, bilateral temporomandibular joint
New code	M06.8A9	Other specified rheumatoid arthritis, unspecified temporomandibular joint

M08 Juvenile arthritis

M08.0 Unspecified Juvenile rheumatoid arthritis

New sub-subcategory	M08.0A	Unspecified juvenile rheumatoid arthritis, temporomandibular joint
New code	M08.0A1	Unspecified juvenile rheumatoid arthritis, right temporomandibular joint
New code	M08.0A2	Unspecified juvenile rheumatoid arthritis, left temporomandibular joint
New code	M08.0A3	Unspecified juvenile rheumatoid arthritis, bilateral temporomandibular joint
New code	M08.0A9	Unspecified juvenile rheumatoid arthritis, unspecified temporomandibular joint

M08.2 Juvenile rheumatoid arthritis with systemic onset

New sub-subcategory	M08.2A	Juvenile rheumatoid arthritis with systemic onset, temporomandibular joint
New code	M08.2A1	Juvenile rheumatoid arthritis with systemic onset, right temporomandibular joint
New code	M08.2A2	Juvenile rheumatoid arthritis with systemic onset, left temporomandibular joint

New code	M08.2A3	Juvenile rheumatoid arthritis with systemic onset, bilateral temporomandibular joint
New code	M08.2A9	Juvenile rheumatoid arthritis with systemic onset, unspecified temporomandibular joint

M08.4 Pauciarticular juvenile rheumatoid arthritis

New sub-subcategory	M08.4A	Pauciarticular juvenile rheumatoid arthritis, temporomandibular joint
New code	M08.4A1	Pauciarticular juvenile rheumatoid arthritis, right temporomandibular joint
New code	M08.4A2	Pauciarticular juvenile rheumatoid arthritis, left temporomandibular joint
New code	M08.4A3	Pauciarticular juvenile rheumatoid arthritis, bilateral temporomandibular joint
New code	M08.4A9	Pauciarticular juvenile rheumatoid arthritis, unspecified temporomandibular joint

M08.8 Other juvenile arthritis

New sub-subcategory	M08.8A	Other juvenile arthritis, temporomandibular joint
New Code	M08.8A1	Other juvenile rheumatoid arthritis, right temporomandibular joint
New Code	M08.8A2	Other juvenile rheumatoid arthritis, left temporomandibular joint
New Code	M08.8A3	Other juvenile rheumatoid arthritis, bilateral temporomandibular joint
New Code	M08.8A9	Other juvenile rheumatoid arthritis, unspecified temporomandibular joint

M08.9 Juvenile arthritis, unspecified

New sub-subcategory	M08.9A	Juvenile arthritis, unspecified temporomandibular joint
New code	M08.9A1	Juvenile arthritis, unspecified, right temporomandibular joint
New code	M08.9A2	Juvenile arthritis, unspecified, left temporomandibular joint
New Code	M08.9A3	Juvenile arthritis, unspecified, bilateral temporomandibular joint
New code	M08.9A9	Juvenile arthritis, unspecified, unspecified temporomandibular joint

M12 Other and unspecified arthropathy

M12.5 Traumatic arthropathy

New sub-subcategory M12.5A Traumatic arthropathy, temporomandibular joint

New Code M12.5A1 Traumatic arthropathy, right temporomandibular joint

New Code M12.5A2 Traumatic arthropathy, left temporomandibular joint

New Code M12.5A3 Traumatic arthropathy, bilateral temporomandibular joint

New Code M12.5A9 Traumatic arthropathy, unspecified temporomandibular joint

M12.8 Other specific arthropathies, not elsewhere classified

New sub-subcategory M12.8A Other specific arthropathies, not elsewhere classified temporomandibular joint

New Code M12.8A1 Other specific arthropathies, not elsewhere classified, right temporomandibular joint

New Code M12.8A2 Other specific arthropathies, not elsewhere classified, left temporomandibular joint

New Code M12.8A3 Other specific arthropathies, not elsewhere classified, bilateral temporomandibular joint

New Code M12.8A9 Other specific arthropathies, not elsewhere classified, unspecified temporomandibular joint

M19 Other and unspecified osteoarthritis

M19.0 Primary osteoarthritis of other joints

New sub-subcategory M19.0A Primary osteoarthritis, temporomandibular joint

New code M19.0A1 Primary osteoarthritis, right temporomandibular joint

New code M19.0A2 Primary osteoarthritis, left temporomandibular joint

New code M19.0A3 Primary osteoarthritis, bilateral temporomandibular joint

New code M19.0A9 Primary osteoarthritis, unspecified temporomandibular joint

M19.1 Post-traumatic osteoarthritis of other joints

New sub-subcategory	M19.1A	Post-traumatic osteoarthritis, temporomandibular joint
New code	M19.1A1	Post-traumatic osteoarthritis, right temporomandibular joint
New code	M19.1A2	Post-traumatic osteoarthritis, left temporomandibular joint
New code	M19.1A3	Post-traumatic osteoarthritis, bilateral temporomandibular joint
New code	M19.1A9	Post-traumatic osteoarthritis, unspecified temporomandibular joint

M19.2 Secondary osteoarthritis of other joints

New sub-subcategory	M19.2A	Secondary osteoarthritis, temporomandibular joint
New code	M19.2A1	Secondary osteoarthritis, right temporomandibular joint
New code	M19.2A2	Secondary osteoarthritis, left temporomandibular joint
New code	M19.2A3	Secondary osteoarthritis, bilateral temporomandibular joint
New code	M19.2A9	Secondary osteoarthritis, unspecified temporomandibular joint

M24 Other specific joint derangement

M24.0 Loose body in joint

New sub-subcategory	M24.0A	Loose body in joint, temporomandibular joint
New code	M24.0A1	Loose body in right temporomandibular joint
New code	M24.0A2	Loose body in left temporomandibular joint
New code	M24.0A3	Loose body in bilateral temporomandibular joint
New code	M24.0A9	Loose body in unspecified temporomandibular joint

M24.1 Other articular cartilage disorders

New sub-subcategory M24.1A Other articular cartilage disorders, temporomandibular joint

New code M24.1A1 Other articular cartilage disorders, right temporomandibular joint

New code M24.1A2 Other articular cartilage disorders, left temporomandibular joint

New code M24.1A3 Other articular cartilage disorders, bilateral temporomandibular joint

New code M24.1A9 Other articular cartilage disorders, unspecified temporomandibular joint

M24.2 Disorder of ligament

New sub-subcategory M24.2A Disorder of ligament, temporomandibular joint

New code M24.2A1 Disorder of ligament, right temporomandibular joint

New code M24.2A2 Disorder of ligament, left temporomandibular joint

New code M24.2A3 Disorder of ligament, bilateral temporomandibular joint

New code M24.2A9 Disorder of ligament, unspecified temporomandibular joint

M24.3 Pathological dislocation of joint, not elsewhere classified

New sub-subcategory M24.3A Pathological dislocation of temporomandibular joint, not elsewhere classified

New code M24.3A1 Pathological dislocation of right temporomandibular joint, not elsewhere classified

New code M24.3A2 Pathological dislocation of left temporomandibular joint, not elsewhere classified

New code M24.3A3 Pathological dislocation of bilateral temporomandibular joint, not elsewhere classified

New code M24.3A9 Pathological dislocation of unspecified temporomandibular joint, not elsewhere classified

M24.4 Recurrent dislocation of joint

New sub-subcategory	M24.4A	Recurrent dislocation, temporomandibular joint
New code	M24.4A1	Recurrent dislocation, right temporomandibular joint
New code	M24.4A2	Recurrent dislocation, left temporomandibular joint
New code	M24.4A3	Recurrent dislocation, bilateral temporomandibular joint
New code	M24.4A9	Recurrent dislocation, unspecified temporomandibular joint

M24.5 Contracture of joint

New sub-subcategory	M24.5A	Contracture of temporomandibular joint
New code	M24.5A1	Contracture, right temporomandibular joint
New code	M24.5A2	Contracture, left temporomandibular joint
New code	M24.5A3	Contracture, bilateral temporomandibular joint
New code	M24.5A9	Contracture, unspecified temporomandibular joint

M24.6 Ankylosis of joint

New sub-subcategory	M24.6A	Bony ankylosis, temporomandibular joint
New code	M24.6A1	Bony ankylosis, right temporomandibular joint
New code	M24.6A2	Bony ankylosis, left temporomandibular joint
New code	M24.6A3	Bony ankylosis, bilateral temporomandibular joint
New code	M24.6A9	Bony ankylosis, unspecified temporomandibular joint
New sub-subcategory	M24.6B	Fibrous ankylosis, temporomandibular joint
New code	M24.6A1	Fibrous ankylosis, right temporomandibular joint
New code	M24.6A2	Fibrous ankylosis, left temporomandibular joint
New code	M24.6A3	Fibrous ankylosis, bilateral temporomandibular joint

New code M24.6A9 Fibrous ankylosis, unspecified temporomandibular joint

M24.8 Other specified joint derangement, not elsewhere classified

New sub-subcategory M24.8A Other specified joint derangement of temporomandibular joint, not elsewhere classified

New code M24.8A1 Other specified joint derangement of right temporomandibular joint, not elsewhere classified
New code M24.8A2 Other specified joint derangement of left temporomandibular joint, not elsewhere classified
New code M24.8A3 Other specified joint derangement of bilateral temporomandibular joint, not elsewhere classified
New code M24.8A9 Other specified joint derangement of temporomandibular joint, not elsewhere classified

M25 Other joint disorder, not elsewhere classified

M25.0 Hemarthrosis

New sub-subcategory M25.0A Hemarthrosis, temporomandibular joint

New code M25.0A1 Hemarthrosis, right temporomandibular joint
New code M25.0A2 Hemarthrosis, left temporomandibular joint
New code M25.0A3 Hemarthrosis, bilateral temporomandibular joint
New code M25.0A9 Hemarthrosis, unspecified temporomandibular joint

M25.1 Fistula of joint

New sub-subcategory M25.1A Fistula, temporomandibular joint
New code M25.1A1 Fistula, right temporomandibular joint
New code M25.1A2 Fistula, left temporomandibular joint
New code M25.1A3 Fistula, bilateral temporomandibular joint
New code M25.1A9 Fistula, unspecified temporomandibular joint

M25.2 Flail joint

New

sub-subcategory	M25.2A		Flail temporomandibular joint
New code		M25.2A1	Flail, right temporomandibular joint
New code		M25.2A2	Flail, left temporomandibular joint
New code		M25.2A3	Flail, bilateral temporomandibular joint
New code		M25.2A9	Flail, unspecified temporomandibular joint

M25.3 Other instability of joint

New sub-subcategory	M25.3A		Other instability, temporomandibular joint
New code		M25.3A1	Other instability, right temporomandibular joint
New code		M25.3A2	Other instability, left temporomandibular joint
New code		M25.3A3	Other instability, bilateral temporomandibular joint
New code		M25.3A9	Other instability, unspecified temporomandibular joint

M25.4 Effusion of joint

New sub-subcategory	M25.4A		Effusion, temporomandibular joint
New code		M25.4A1	Effusion, right temporomandibular joint
New code		M25.4A2	Effusion, left temporomandibular joint
New code		M25.4A3	Effusion, bilateral temporomandibular joint
New code		M25.4A9	Effusion, unspecified temporomandibular joint

M25.5 Pain in joint

New sub-subcategory	M25.5A		Pain, temporomandibular joint
New code		M25.5A1	Pain, right temporomandibular joint
New code		M25.5A2	Pain, left temporomandibular joint
New code		M25.5A3	Pain, bilateral temporomandibular joint
New code		M25.5A9	Pain, unspecified temporomandibular joint

M25.6 Stiffness of joint, not elsewhere classified

New sub-subcategory M25.6A Stiffness of temporomandibular joint, not elsewhere classified

New code M25.6A1 Stiffness of right temporomandibular joint, not elsewhere classified
New code M25.6A2 Stiffness of left temporomandibular joint, not elsewhere classified
New code M25.6A3 Stiffness of bilateral temporomandibular joint, not elsewhere classified
New code M25.6A9 Stiffness of unspecified temporomandibular joint, not elsewhere classified

M26 Dentofacial anomalies [including malocclusion]

M26.6 Temporomandibular joint disorders

New sub-subcategory M26.64 Arthritis of temporomandibular joint

New code M26.641 Arthritis, right temporomandibular joint
New code M26.642 Arthritis, left temporomandibular joint
New code M26.643 Arthritis, bilateral temporomandibular joint
New code M26.649 Arthritis, unspecified temporomandibular joint

M65 Synovitis and tenosynovitis

M65.8 Other synovitis and tenosynovitis

New sub-subcategory M65.8A Other synovitis and tenosynovitis, temporomandibular joint

New code M26.8A1 Other synovitis and tenosynovitis, right temporomandibular joint
New code M26.8A2 Other synovitis and tenosynovitis, left temporomandibular joint
New code M26.8A3 Other synovitis and tenosynovitis, bilateral temporomandibular joint
New code M26.8A9 Other synovitis and tenosynovitis, unspecified temporomandibular joint

Transverse vaginal septum

The American Congress of Obstetricians and Gynecologists (ACOG) is requesting new code(s) to expand the codes for reporting doubling of uterus with doubling of cervix and vagina without/with obstruction, transverse vaginal septum.

The American Congress of Obstetricians and Gynecologists (ACOG) is requesting expansion of the code for doubling of uterus with doubling of cervix and vagina without/with obstruction, transverse vaginal septum to differentiate between varying degrees of complexity of this condition. This proposal was originally submitted in 2015, however NCHS had questions about the proposal and requested ACOG's support in refining the proposal and eliminating definitions in the code descriptions.

A transverse vaginal septum is a congenital anomaly of the female reproductive tract. This is a disorder of vertical fusion between the müllerian ducts and the urogenital sinus system. The prevalence is reported to be 1 in 30,000 to 1 in 84,000. The degree of malformation runs from a simple low thin septum to almost complete vaginal agenesis with only a small functioning upper segment of vagina. A transverse vaginal septum can be composed of fibrous connective tissue and vascular muscular elements with the lower surface covered by squamous elements. The transverse septum can be complete (obstructing) or perforate (nonobstructing). While the literature typically quotes the location of transverse vaginal septa as low (incidence 14%), mid (40%) and high (46%) from John Rock's classic paper, this may reflect the experience at a tertiary referral center. The incidence of low transverse septa may be under-reported if this condition is commonly repaired by general gynecologists.

Transverse septums may be described/localized in the vagina as follows:
Low transverse vaginal septum (originating in lower 1/3 of vagina)
Mid transverse vaginal septum (originating in middle 1/3 of vagina)
High transverse vaginal septum (originating in upper 1/3 of vagina)

The surgical approach and risk for post-operative complications, particularly vaginal stenosis, varies significantly among the different septum locations. A simple low transverse septum or simple septum (=<2cm) can usually be repaired by a straight-forward pull through approach and does not always require highly specialized training to perform the procedure. A thicker, deeper septum or complex septum (>=2cm) requires a more complex procedure involving mobilization of the vagina, and pre-operative dilation of the distal vagina is commonly employed. This process necessitates a delay in the surgical repair, thus medication is required to induce amenorrhea. Finally, a septum that involves partial vaginal agenesis may require the use of a tissue graft (bowel, buccal mucosa, skin, etc.) between the functioning upper vagina and perineum. Hence, the more complex the transverse septum, the greater degree of surgical specialization required for an optimal outcome. The differentiation between levels of septum complexity based on location and length will enable better tracking of these diagnoses and surgical outcomes.

ACOG proposes the following tabular modifications:

TABULAR MODIFICATION

Q52 Other congenital malformations of female genitalia

Q52.1 Doubling of vagina

Q52.11 Transverse vaginal septum

Revise Excludes1~~1~~2: ~~doubling of vagina with doubling of uterus and cervix (Q51.1)~~

New sub-subcategory Q52.1A Transverse vaginal septum, low, non-obstructing

New code Q52.1A0 Transverse vaginal septum, low, non-obstructing, simple

New code Q52.1A1 Transverse vaginal septum, low, non-obstructing, complex

New code Q52.1A9 Transverse vaginal septum, low, non-obstructing, unspecified

New sub-subcategory Q52.1B Transverse vaginal septum, low, obstructing

New code Q52.1B0 Transverse vaginal septum, low, obstructing, simple

New code Q52.1B1 Transverse vaginal septum, low, obstructing, complex

New code Q52.1B9 Transverse vaginal septum, low, obstructing, unspecified

New sub-subcategory Q52.1C Transverse vaginal septum, mid, non-obstructing

New code Q52.1C0 Transverse vaginal septum, mid, non-obstructing, simple

New code Q52.1C1 Transverse vaginal septum, mid, non-obstructing, complex

New code Q52.1C9 Transverse vaginal septum, mid, non-obstructing, unspecified

New sub-subcategory Q52.1D Transverse vaginal septum, high, obstructing

New code Q52.1D0 Transverse vaginal septum, mid, obstructing, simple

New code Q52.1D1 Transverse vaginal septum, mid, obstructing, complex

New code	Q52.1D9 Transverse vaginal septum, mid, obstructing, unspecified
New sub-subcategory	Q52.1E Transverse vaginal septum, high, non-obstructing
New code	Q52.1E0 Transverse vaginal septum, high, non-obstructing, simple
New code	Q52.1E1 Transverse vaginal septum, high, non-obstructing, complex
New code	Q52.1E9 Transverse vaginal septum, high, non-obstructing, unspecified
New sub-subcategory	Q52.1F Transverse vaginal septum, high, non-obstructing
New code	Q52.1F0 Transverse vaginal septum, high, obstructing, simple
New code	Q52.1F1 Transverse vaginal septum, high, obstructing, complex
New code	Q52.1F9 Transverse vaginal septum, high, obstructing, unspecified

Williams Syndrome

Williams syndrome (WS) (also known as Williams Beuren syndrome (WBS) is a multi-system, neurodevelopmental disorder that affects approximately 1/7,500 to 1/10,000 persons. It is a genetic disorder caused by a "micro-deletion" on the long arm of chromosome 7 (7q11.23) associated with loss of 26-28 contiguous genes. Both medical and cognitive problems are present throughout the lifespan of those with Williams syndrome (Pober, 2010). Paramount medical problems include cardiovascular abnormalities, various endocrine abnormalities, gastrointestinal issues and musculoskeletal problems (Morris, 2017; Pober, 2010).

Neurodevelopmental aspects include mild-moderate intellectual disability and learning disabilities. Anxiety and other behavioral/emotional issues are typical. There is relative strength of ability in rote learning and certain verbal skills, and in music, with weakness in visuospatial ability (Pober, 2010). The contributions to the Williams syndrome phenotype from each of the deleted 26-28 genes are increasingly known; current knowledge is greatest surrounding the role of the elastin (ELN) gene deletion.

Individuals with Williams syndrome share common facial features. Children usually have a small upturned nose, long philtrum, delicate jaw, and puffinesss around the eyes, while adolescents and adults have some mild coarsening of these features and are more likely to display a bulbous nose, wide mouth and full lips. A stellate pattern in the iris of blue eyed individuals lasts across the lifespan (Morris, 2017). Developmental delays and learning disabilities are also common in children with Williams syndrome.

There is currently no specific ICD-10-CM code for Williams syndrome. As a microdeletion syndrome, it would be appropriate to assign it code Q93.88, Other microdeletions. Additional codes should be assigned to identify specific findings and related disorders that may be associated, and may require specific medical care.

The Williams Syndrome Association has requested creation of a specific code for Williams syndrome. Having a specific code for Williams syndrome will provide opportunities for research, will assist in more accurately determining the true frequency of this disorder and to identify people who could participate in research, and enable surveillance for the disorder. This in turn may provide insight into management and treatment of this syndrome, and development of management and treatment guidelines, helping the scientific community find critical answers about the many medical and cognitive issues for those with Williams syndrome.

References

Williams Syndrome. Genetics Home Reference. NLM, NIH. 2017. https://ghr.nlm.nih.gov/condition/williams-syndrome

Morris CA. Williams Syndrome. 1999 Apr 9 [Updated 2017 Mar 23]. In: Pagon RA, Adam MP,Ardinger HH, et al., editors. GeneReviews® [Internet]. Seattle (WA): University of Washington,Seattle; 1993-2017. Available from: https://www.ncbi.nlm.nih.gov/books/NBK1249/.

Pober BR. Williams–Beuren Syndrome. N Engl J Med 2010; 362:239-252. https://doi.org/10.1056/NEJMra0903074

TABULAR MODIFICATION

Q93 Monosomies and deletions from the autosomes, not elsewhere classified
Q93.8 Other deletions from the autosomes
Q93.81 Velo-cardio-facial syndrome
Deletion 22q11.2
New code Q93.82 Williams Syndrome

Zika Virus Related Newborn Conditions

In 2016, the American Academy of Pediatrics and the CDC convened a work group consisting of representatives of the CDC, along with physicians representing fetal and newborn medicine, infectious disease pediatrics, developmental and behavioral pediatrics, neurology, and disaster preparedness personnel who are dealing with this public health issue. The workgroup indicated that it is critical that we accurately capture infected in utero or neonates manifesting clinical findings of the Zika virus infection. At the September 2016 ICD-10 Coordination and Maintenance meeting, the CDC-American Academy of Pediatrics Zika workgroup requested that specific codes be created in order to identify and monitor these infants who are at risk or infected with the virus and who may require additional resources for their care.

At the October 2016 WHO Update and Reference Committee (URC) meeting, new ICD-10 codes were proposed for a Zika virus infection (A92.5, Zika virus disease), and for P35.4, Congenital Zika virus infection. The proposal was deferred to the October 2017 URC meeting for further discussion because of issues regarding the impact of the proposed codes on other codes in ICD-10. The proposal will be voted on during the annual URC meeting in October 2017. Code A92.5, Zika virus disease, was implemented in ICD-10-CM, effective October 1, 2016.

As noted above, the AAP/CDC proposal was originally presented at the September 2016 Coordination and Maintenance meeting, but is being re-presented with modifications based on the WHO URC proposal under consideration by WHO for the ICD-10 update. If the codes and related changes are approved by WHO, the new codes would be included in the ICD-10-CM, effective October 1, 2018.

TABULAR MODIFICATIONS

A92 Other mosquito-borne viral fevers
A92.5 Zika virus disease
Zika virus fever
Zika virus infection
Zika, NOS
Add Excludes1: congenital Zika virus disease (P35.4)

P00 Newborn affected by maternal conditions that may be unrelated to present pregnancy

P00.2 Newborn affected by maternal infectious and parasitic diseases
Newborn affected by maternal infectious disease classifiable to A00-B99, J09 and J10

New code P00.21 Newborn affected by maternal infection with Zika virus
Code also any associated manifestations

New code P00.29 Newborn affected by other maternal infection

P35 Congenital viral diseases

New code P35.4 Congenital Zika virus infection
Use additional code to identify manifestations of congenital Zika virus disease

Q02 Microcephaly

Add Use additional code, if applicable, to identify congenital Zika virus disease

Z20 Contact with and (suspected) exposure to communicable diseases

Z20.8 Contact with and (suspected) exposure to other communicable diseases

Z20.82 Contact with and (suspected) exposure to other viral communicable diseases

New code Z20.821 Contact with and (suspected) exposure to Zika virus

ICD-10-CM TABULAR OF DISEASES - PROPOSED ADDENDA

All proposed effective October 1, 2018

B39 Histoplasmosis
Use additional code for any associated manifestations, such as:
Revise retinitits ~~retinitits~~ retinitis (H32)

B51 Plasmodium vivax malaria
Revise Excludes1: plasmodium ~~vivav~~ vivax with Plasmodium falciparum (B50.-)

D47 Other neoplasms of uncertain behavior of lymphoid, hematopoietic and related tissue
Revise Excludes1: congenital cutaneous mastocytosis ~~(Q82.2-)~~ (Q82.2)

E67 Other hyperalimentation
Revise E67.1 ~~Hypercarotinemia~~ Hypercarotenemia

E85 Amyloidosis
Revise Excludes2: Alzheimer's disease ~~(G30.0-)~~ (G30.0)

F19 Other psychoactive substance related disorders
F19.2 Other psychoactive substance dependence
F19.21 Other psychoactive substance dependence, in remission
Revise Other (or unknown) substance use disorder, severe, in sustained remission

F19.9 Other psychoactive substance use, unspecified
F19.98 Other psychoactive substance use, unspecified with other psychoactive substance-induced disorders
F19.988 Other psychoactive substance use, unspecified with other psychoactive substance-induced disorder
Revise Other (or unknown) substance-induced obsessive-compulsive or ~~relateddisorder~~ related disorder, without use disorder

G24 Dystonia
G24.0 Drug induced dystonia
Revise Use additional code ~~code~~ for adverse effect, if applicable, to identify drug (T36-T50 with fifth or sixth character 5)

I27 Other pulmonary heart diseases
I27.2 Other secondary pulmonary hypertension
I27.29 Other secondary pulmonary hypertension
Code also other associated disorders, if known, such as:

Revise hypertensive chronic kidney disease with end stage renal disease (I12.0, ~~I12.11~~, I13.2 I13.11)

Cerebrovascular diseases (I60-I69)
Use additional code to identify presence of:
Revise hypertension (I10-~~I15~~ I16)

I63 Cerebral infarction
I63.2 Cerebral infarction due to unspecified occlusion or stenosis of precerebral arteries
I63.21 Cerebral infarction due to unspecified occlusion or stenosis of vertebral arteries
Revise I63.219 Cerebral infarction due to unspecified occlusion or stenosis of unspecified vertebral ~~arteries~~ artery
I63.23 Cerebral infarction due to unspecified occlusion or stenosis of carotid arteries
I63.239 Cerebral infarction due to unspecified occlusion or stenosis of unspecified carotid ~~arteries~~ artery

I63.3 Cerebral infarction due to thrombosis of cerebral arteries
I63.33 Cerebral infarction due to thrombosis of posterior cerebral artery
Revise I63.333 Cerebral infarction due to thrombosis of bilateral posterior cerebral arteries
I63.34 Cerebral infarction due to thrombosis of cerebellar artery
Revise I63.343 Cerebral infarction due to thrombosis of bilateral cerebellar arteries

I44 Atrioventricular and left bundle-branch block
I44.1 Atrioventricular block, second degree
Revise Möbitz block ~~block~~, type I and II

I72 Other aneurysm
Revise Excludes2: precerebral artery, ~~congential~~ congenital (nonruptured) (Q28.1)

I77 Other disorders of arteries and arterioles
I77.6 Arteritis, unspecified
Revise giant cell (M31.5~~.~~, M31.6)

J10 Influenza due to other identified influenza virus
Revise Excludes1: influenza due to ~~unidentifed~~ unidentified influenza virus (J11.-)

K43 Ventral hernia
Revise K43.5 Parastomal hernia without obstruction or -gangrene

K52 Other and unspecified noninfective gastroenteritis and colitis
K52.2 Allergic and dietetic gastroenteritis and colitis
K52.21 Food protein-induced enterocolitis syndrome
Add FPIES

L98 Other disorders of skin and subcutaneous tissue, not elsewhere classified
L98.4 Non-pressure chronic ulcer of skin, not elsewhere classified
L98.49 Non-pressure chronic ulcer of skin of other sites
Revise L98.495 Non-pressure chronic ulcer of skin of other sites with muscle involvement without evidence of necrosis
Revise L98.496 Non-pressure chronic ulcer of skin of other sites with bone involvement without evidence of necrosis
Revise L98.498 Non-pressure chronic ulcer of skin of other sites with other specified severity

CHAPTER 13
Diseases of the musculoskeletal system and connective tissue (M00-M99)

This chapter contains the following blocks:
Add M04 Autoinflammatory syndromes
Add M97 Periprosthetic fracture around internal prosthetic joint

M26 Dentofacial anomalies [including malocclusion]
M26.6 Temporomandibular joint disorders
M26.62 Arthralgia of temporomandibular joint
Revise M26.621 Arthralgia of right temporomandibular -joint

M50 Cervical disc disorders
M50.0 Cervical disc disorder with myelopathy
Revise M50.01 Cervical disc disorder with myelopathy, -high cervical region

M50.1 Cervical disc disorder with radiculopathy
Revise M50.11 Cervical disc disorder with radiculopathy, -high cervical region

M50.2 Other cervical disc displacement
Revise M50.21 Other cervical disc displacement, -high cervical region

M50.3 Other cervical disc degeneration
Revise M50.31 Other cervical disc degeneration, -high cervical region

M50.8 Other cervical disc disorders
Revise M50.81 Other cervical disc disorders, -high cervical region

M50.9 Cervical disc disorder, unspecified
Revise M50.91 Cervical disc disorder, unspecified, -high cervical region

M86 Osteomyelitis
M86.6 Other chronic osteomyelitis
Revise M86.62 Other chronic osteomyelitis, -humerus
Revise M86.621 Other chronic osteomyelitis, right -humerus
Revise M86.622 Other chronic osteomyelitis, left -humerus
Revise M86.629 Other chronic osteomyelitis, unspecified -humerus

N63 Unspecified lump in breast
Revise N63.0 Unspecified lump in unspecified -breast

P78 Other perinatal digestive system disorders
P78.8 Other specified perinatal digestive system disorders
P78.84 Gestational alloimmune liver disease
Revise Excludes-1:

P91 Other disturbances of cerebral status of newborn
P91.8 Other specified disturbances of cerebral status of newborn
P91.81 Neonatal encephalopathy
P91.811 Neonatal encephalopathy in diseases classified elsewhere
Code first underlying condition, if known, such as:
Revise congenital cirrhosis (of liver) ~~(P78.71)~~ P78.81

Q66 Congenital deformities of feet
Q66.8 Other congenital deformities of feet
Revise Q66.89 Other -specified congenital deformities of feet

CHAPTER 17
Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)

Revise Note: Codes from this chapter are not for use on maternal ~~or fetal~~ records

S60 Superficial injury of wrist, hand and fingers
S62.6 Fracture of other and unspecified finger(s)
S62.62 Displaced fracture of middle phalanx of finger
Revise S62.626 Displaced fracture of ~~medial~~ middle phalanx of right little finger

Revise S62.627 Displaced fracture of ~~medial~~ middle phalanx of left little finger

Revise S62.628 Displaced fracture of ~~medial~~ middle phalanx of other finger

Revise Displaced fracture of ~~medial~~ middle phalanx of specified finger with unspecified laterality

Revise S62.629 Displaced fracture of ~~medial~~ middle phalanx of unspecified finger

S62.65 Nondisplaced fracture of middle phalanx of finger

Revise S62.654 Nondisplaced fracture of ~~medial~~ middle phalanx of right ring finger

Revise S62.655 Nondisplaced fracture of ~~medial~~ middle phalanx of left ring finger

Revise S62.656 Nondisplaced fracture of ~~medial~~ middle phalanx of right little finger

Revise S62.657 Nondisplaced fracture of ~~medial~~ middle phalanx of left little finger

Revise S62.658 Nondisplaced fracture of ~~medial~~ middle phalanx of other finger

Revise Nondisplaced fracture of ~~medial~~ middle phalanx of specified finger with unspecified laterality

Revise S62.659 Nondisplaced fracture of ~~medial~~ middle phalanx of unspecified finger

S99 Other and unspecified injuries of ankle and foot

S99.1 Physeal fracture of metatarsal

S99.10 Unspecified physeal fracture of metatarsal

Revise S99.101 Unspecified physeal fracture of right ~~-~~metatarsal

S99.13 Salter-Harris Type III physeal fracture of metatarsal

Revise S99.132 Salter-Harris Type III physeal fracture of left ~~-~~ metatarsal

T21 Burn and corrosion of trunk

T21.0 Burn of unspecified degree of trunk

T21.01 Burn of unspecified degree of chest wall

Revise Burn of ~~of~~ unspecified degree of breast

T74 Adult and child abuse, neglect and other maltreatment, confirmed

T74.3 Psychological abuse, confirmed

Add Bullying and intimidation

T76 Adult and child abuse, neglect and other maltreatment, suspected
T76.3 Psychological abuse, suspected
Add Bullying and intimidation
Add Intimidation through social media

T80 Complications following infusion, transfusion and therapeutic injection
T80.3 ABO incompatibility reaction due to transfusion of blood or blood products
Revise Excludes1: minor blood group antigens reactions (Duffy) (E) ~~(K(ell))~~ (Kell) (Kidd) (Lewis) (M) (N) (P) (S) (T80.A)

T81 Complications of procedures, not elsewhere classified
T81.1 Postprocedural shock
Revise T81.11 Postprocedural ~~-~~cardiogenic shock

CHAPTER 20
External causes of morbidity (V00-Y99)

This chapter contains the following blocks:
Add X50 Overexertion and strenuous or repetitive movements

V00 Pedestrian conveyance accident
V00.1 Rolling-type pedestrian conveyance accident
Revise Excludes1: accident with ~~babystroller~~ baby stroller (V00.82-)
V00.14 Scooter (nonmotorized) accident
Revise Excludes1: ~~motorscooter~~ motor scooter accident (V20-V29)

V00.2 Gliding-type pedestrian conveyance accident
V00.21 Ice-skates accident
V00.218 Other ice-skates accident
Revise Excludes1: ice-skater collision with other land transport vehicle (V01-V09 with 5th ~~digit~~ character 9)
V00.22 Sled accident
V00.228 Other sled accident
Revise Excludes1: sled collision with other land transport vehicle (V01-V09 with 5th ~~digit~~ character 9)

V00.3 Flat-bottomed pedestrian conveyance accident
V00.31 Snowboard accident
V00.318 Other snowboard accident
Revise Excludes1: snowboarder collision with other land transport vehicle (V01-V09 with 5th ~~digit~~ charcter 9)

V00.32 Snow-ski accident
V00.328 Other snow-ski accident
Revise Excludes1: snow-skier collision with other land transport vehicle (V01-V09 with 5th ~~digit~~ charcter 9)

V00.8 Accident on other pedestrian conveyance

Revise V00.82 Accident with ~~babystroller~~ baby stroller
Revise V00.821 Fall from ~~babystroller~~ baby stroller
Revise V00.822 ~~babystroller~~ baby stroller colliding with stationary object
Revise V00.828 Other accident with ~~babystroller~~ baby stroller

V00.89 Accident on other pedestrian conveyance
V00.898 Other accident on other pedestrian conveyance
Revise Excludes1: other pedestrian (conveyance) collision with other land transport vehicle (V01-V09 with 5th ~~digit~~ character 9)

X37 Cataclysmic storm
X37.9 Unspecified cataclysmic storm
Revise Excludes1: collapse of dam or man-made structure causing earth movement (~~X39.0~~ X36.0)

X38 Flood
Revise Excludes1: collapse of dam or man-made structure causing earth movement (~~X39.0~~ X36.0)
Revise tidal wave caused by storm ~~(X37.2)~~ (X37.42)

X39 Exposure to other forces of nature
X39.0 Exposure to natural radiation
Revise Excludes1: contact with and (suspected) exposure to radon and other naturally ~~occuring~~ occurring radiation (Z77.123)

Medical devices associated with adverse incidents in diagnostic and therapeutic use (Y70-Y82)
Delete Excludes2:~~breakdown or malfunctioning of medical device (after implantation) (during procedure) (ongoing use) (Y70-Y82)~~

Y92 Place of occurrence of the external cause
Y92.0 Non-institutional (private) residence as the place of occurrence of the external cause
Y92.00 Unspecified non-institutional (private) residence as the place of occurrence of the external cause
Revise Y92.000 Kitchen of unspecified non-institutional (private) residence as -the place of occurrence of the external cause

Y93 Activity codes
Y93.2 Activities involving ice and snow
Y93.23 Activity, snow (alpine) (downhill) skiing, ~~snow boarding~~ snowboarding, sledding, tobogganing and snow tubing

CHAPTER 21
Factors influencing health status and contact with health services (Z00-Z99)

This chapter contains the following blocks:

Add Z19 Hormone sensitivity malignancy status

Z03 Encounter for medical observation for suspected diseases and conditions ruled out

Revise Excludes1: encounter for observation and evaluation of newborn for suspected diseases and conditions ruled out (Z05.~~0~~-) (Z05.-)

Z18 Retained foreign body fragments
Z18.2 Retained plastic fragments

Revise ~~Diethylhexylphthalates~~ Diethylhexyl phthalates fragments

Z29 Encounter for other prophylactic measures

Revise ~~Excludes 1~~ Excludes1:

Z40 Encounter for prophylactic surgery
Z40.0 Encounter for prophylactic surgery for risk factors related to malignant neoplasms

Revise Z40.03 Encounter for prophylactic removal of fallopian tube~~(s)~~ (tube(s)

Z77 Other contact with and (suspected) exposures hazardous to health
Z77.1 Contact with and (suspected) exposure to environmental pollution and hazards in the physical environment
Z77.12 Contact with and (suspected) exposure to hazards in the physical environment

Revise Z77.123 Contact with and (suspected) exposure to radon and other naturally ~~occuring~~ occurring radiation

Z95 Presence of cardiac and vascular implants and grafts
Z95.8 Presence of other cardiac and vascular implants and grafts
Z95.81 Presence of other cardiac implants and grafts
Z95.810 Presence of automatic (implantable) cardiac defibrillator

Revise Presence of cardioverter-~~defribillator~~ defibrillator (ICD)

ICD-10-CM INDEX OF DISEASES - PROPOSED ADDENDA

All proposed effective October 1, 2018

Abscess
Delete - gingival - see Peridontitis, ~~aggressive,~~ localized
Delete - gum - see Peridontitis, ~~aggressive,~~ localized

Angiitis I77.6
Add - leukocytoclastic M31.0
Add - - cutaneous M31.0

Balanitis (circinata) (erosiva) (gangrenosa) (phagedenic) (vulgaris) N48.1
Revise - gonococcal (acute) (chronic) ~~A54.09~~ A54.23

Balanoposthitis N47.6
Revise - gonococcal (acute) (chronic) ~~A54.09~~ A54.23

Bruise (skin surface intact) - see also Contusion
- with
Revise - - open wound - see Wound, ~~ope~~ open

Revise ~~Carotinemia~~ Carotenemia (dietary) E67.1
Revise ~~Carotinosis~~ Carotenosis (cutis) (skin) E67.1

Revise Concealed penis ~~Q55.69~~ Q55.64

Dislocation (articular)
- interphalangeal (joint(s))
- - thumb S63.10-
Delete ~~- - - distal joint S63.14-~~
Delete ~~- - - proximal joint S63.13-~~

Disease
Add - autoinflammatory M04.9
Add - - NOD2-associated M04.8
Add - - specified type NEC M04.8

Dissection
Revise - ~~precerbral~~ precerebral artery, ~~congential~~ congenital (nonruptured) Q28.1

Dystonia G24.9
Add - cervical G24.3

Enteritis (acute) (diarrheal) (hemorrhagic) (noninfective) K52.9
- allergic K52.29
- - with
- - - food protein-induced enterocolitis syndrome K52.21
Add - - - FPIES K52.21
- - - food protein-induced enteropathy K52.22

Fever (inanition) (of unknown origin) (persistent) (with chills) (with rigor) R50.9-
rheumatic (active) (acute) (chronic) (subacute) I00
- rheumatic (active) (acute) (chronic) (subacute) I00
- - inactive or quiescent with
Revise - - - heart failure (congestive) (conditions in Category I50.) I09.81

Revise Hypercarotenemia, ~~hypercarotinemia~~ (dietary) E67.1

Hypertension, hypertensive
Add - transient R03.0

Lesion(s) (nontraumatic)
Add -Vagina N89.8
Add -Vulvar N90.89

Leukemia, leukemic C95.9-
Revise - acute myeloid, NOS C92.0
- myeloid C92.9-
Add - - acute C92.0

Paraplegia (lower) G82.20
Add - traumatic -- code to injury with seventh character S

Place of occurrence
Revise - road ~~Y92.488~~ Y92.410

Polyarteritis
Add - juvenile M30.2
- nodosa M30.0
Add - - childhood M30.2

Rapid
Revise - time-zone change syndrome ~~- see Disorder, sleep, circadian rhythm, psychogenic~~ G47.25

Subluxation - see also Dislocation
- interphalangeal (joint(s))
- - thumb S63.10-
Delete ~~- - - distal joint S63.14-~~
Delete ~~- - - proximal joint S63.13-~~

Syndrome
Add - Yao M04.8

Vasculitis I77.6
Add - hypersensitivity M31.0
Add - leukoclastic M31.0